HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: _____

Patient Name _____ Birthdate _____ Patient # _____

Chief Complaint: _____

History of present illness:

Location: _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration _____
(How long have you had this pain/problem?, or, When did it start?)

Timing _____
(Does the pain/problem occur at a specific time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms _____
(What other associated problems have you been having?)

Modifying factors _____
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray _____			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes			
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes			
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes			
Arthritis	no	yes	Blood or Plasma			Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes	Transfusions	no	yes	Stroke	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications: (Include nonprescription) _____

_____

_____

Have you ever taken Fen-Phen/Redux? no yes

Patient social history:

Marital status Single:_____ Married: _____ Separated: _____ Divorced:_____ Widowed:_____

Use of alcohol: Never:_____ Rarely:_____ Moderate:_____ Daily:_____

Use of tobacco: Never:_____ Previously, but quit:_____ Current packs / day: _____

Use of drugs: Never:_____ Type/Frequency: _____

Excessive exposure at home or work to: Fumes:_____ Dust:_____ Solvents:_____ Air-borne Particles:_____ Noise:_____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

☐ **Eyes**

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes

☐ **Ears/Nose/Mouth/Throat**

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

☐ **Cardiovascular**

Heart trouble	No	Yes
Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath w/walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

☐ **Respiratory**

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

☐ **Gastrointestinal**

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes

☐ **Genitourinary**

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain when urinating	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male - testicle pain	No	Yes
Female - pain with periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge	No	Yes
Female - # of pregnancies	_____	
Female - # of miscarriages	_____	
Female - date of last pap smear	_____	

☐ **Musculoskeletal**

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

☐ **Integumentary (skin, breast)**

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

☐ **Neurological**

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head injury	No	Yes

☐ **Psychiatric**

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

☐ **Endocrine**

Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

☐ **Hematologic/Lymphatic**

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, or other narcotics	No	Yes
Novocain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes
Iodine, Merthiolate or other antiseptic	No	Yes

Other drugs/medications: _____

_____

Known food allergies: _____

_____

Environmental allergies: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibilty to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____

Signature of Patient, Parent or Guardian Date

Doctor's Review

_____ _____

Signature of Doctor Date