

Health History

Name: _____ Date of Birth: _____

Today's Date: _____ Date of last Physician examination _____

SYMPTOMS - Check (✓) symptoms you currently have or have had in the past year.			
<p><u>GENERAL</u></p> <input type="checkbox"/> Appetite change <input type="checkbox"/> Chills <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Loss of weight <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <input type="checkbox"/> Syncope <input type="checkbox"/> Weakness <p><u>EYE, EAR, NOSE, THROAT</u></p> <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Dry eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Eye discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Mouth ulcers <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Painful eyes <input type="checkbox"/> Persistent cough <input type="checkbox"/> Red eyes <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <p><u>CARDIOVASCULAR</u></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Swelling in ankles	<p><u>RESPIRATORY</u></p> <input type="checkbox"/> Asthma <input type="checkbox"/> Allergies <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decrease in exercise capacity <p><u>GASTROINTESTINAL</u></p> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Appetite poor <input type="checkbox"/> Black stools <input type="checkbox"/> Bloating <input type="checkbox"/> Blood in stools <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation or diarrhea <input type="checkbox"/> Gas <input type="checkbox"/> Heartburn or indigestion <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Nausea or vomiting <p><u>GENITO-URINARY</u></p> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urinating <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination <p><u>MUSCLE/JOINT/BONE</u></p> Pain, weakness, numbness in: <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders <p>Other:</p> <input type="checkbox"/> Fatigue <input type="checkbox"/> Sleep problems <input type="checkbox"/> Snoring 	<p><u>SKIN</u></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Change in moles <input type="checkbox"/> Confusion <input type="checkbox"/> Hair loss <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal <input type="checkbox"/> Swollen lymph nodes/glands <p><u>NEUROLOGICAL</u></p> <input type="checkbox"/> Balance problems <input type="checkbox"/> Dizziness or lightheadedness <input type="checkbox"/> Fainting <input type="checkbox"/> Headaches <input type="checkbox"/> Memory problems <input type="checkbox"/> Seizures <input type="checkbox"/> Vision paralysis <input type="checkbox"/> Weakness <p><u>PSYCHIATRIC</u></p> <input type="checkbox"/> Anger <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Nervousness <input type="checkbox"/> Stress <input type="checkbox"/> Trouble concentrating <p><u>ENDOCRINE</u></p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Thirst frequency <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <p><u>HEMATOLOGICAL</u></p> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding disorder	<p><u>ALLERGIES</u></p> <input type="checkbox"/> Asthma <input type="checkbox"/> Hayfever or allergic rhinitis <p><u>WOMEN only</u></p> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Sexually active <input type="checkbox"/> Vaginal discharge Date of last menstrual period <hr/> Date of last mammogram <hr/> Could you be or are you pregnant? Yes _____ No _____ Number of children <hr/> <p><u>MEN only</u></p> <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sexually active Date of last prostate exam <hr/>

Conditions - Check (✓) conditions you have or have had in the past.			
<input type="checkbox"/> Aids <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Ashtma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical dependency <input type="checkbox"/> Chicken pox	<input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes <input type="checkbox"/> HIV positive <input type="checkbox"/> Immune deficiency <input type="checkbox"/> Kidney disease	<input type="checkbox"/> Liver disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraines <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Prostate problem <input type="checkbox"/> Psychiatric care <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Splenectomy <input type="checkbox"/> Spine disease <input type="checkbox"/> Stroke <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal disease