HEALTH HISTORY FORM

Date: _____ Age: _____

Last Name First Name MI

Referring doctor: _____ Primary doctor: _____

Reason you are here: _____

OPERATIONS: (when, type of surgery) **HOSPITALIZATIONS:** (when, where, why?)

_____ _____

_____ _____

_____ _____

_____ _____

MEDICATIONS: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: Circle if you have an allergy to any of the following. Please describe reactions.

Dye_____ Codeine_____
Foods _____ Tape_____
Penicillin_____ Latex_____
Sulfa_____ Erythromycin _____
Iodine_____ Other_____

PERSONAL HISTORY AND HABITS: ❑**Married** ❑**Single** ❑**Widowed**

Employed: ❑No ❑ Yes, occupation: _____

Children: ❑ No ❑ Yes, number of children: _____

Tobacco Use: ❑ Current, # packs daily: _____ ❑ Past, date stopped: _____ ❑Never

Alcohol Use: ❑Current, type/frequency: _____ ❑ Past ❑Never

FAMILY HISTORY: Check all that apply.

M=Mother **F**=Father **GM**= Grandmother **GF**=Grandfather **A**=Aunt **U**=Uncle

Cancer: ❑M ❑F ❑GM ❑GF ❑A ❑U **Cancer Type**: _____

Heart Disease: ❑M ❑F Diabetes: ❑M ❑F Stroke: ❑M ❑F High Blood Pressure: ❑M ❑F

Are parents still living: ❑Yes ❑ No, cause of death: _____

Name:_____

GENERAL

Good general health lately	❑ No	❑Yes
Chills or sweats	❑ No	❑Yes
Fever	❑ No	❑Yes
Fatigue	❑ No	❑Yes

EYES

Recent visual problem	❑ No	❑Yes
Blurred vision	❑ No	❑Yes

EARS/NOSE/THROAT

Decreased hearing	❑ No	❑Yes
Ear pain	❑ No	❑Yes
Nasal congestion	❑ No	❑Yes
Sore throat	❑ No	❑Yes

LUNGS/RESPIRATORY SYSTEM

✪Shortness of breath	❑ No	❑Yes
If yes: ❑At rest ❑With activity ❑Both		
Chronic/frequent cough	❑ No	❑Yes
✪Sleep apnea	❑ No	❑Yes
✪Blood clots in lungs	❑ No	❑Yes
✪Asthma	❑ No	❑Yes
✪COPD	❑ No	❑Yes
✪Tuberculosis	❑ No	❑Yes

HEART/CARDIOVASCULAR SYSTEM

Chest pain	❑ No	❑Yes
✪Palpitations	❑ No	❑Yes
Swelling of the legs	❑ No	❑Yes
Frequent fainting	❑ No	❑Yes
✪Mitral valve prolapse	❑ No	❑Yes
✪Coronary artery disease	❑ No	❑Yes
✪Heart failure	❑ No	❑Yes
✪Heart attack	❑ No	❑Yes, at age_____
Rheumatic fever	❑ No	❑Yes
✪High blood pressure	❑ No	❑Yes

DIGESTIVE/G.I. SYSTEM

Nausea and vomiting	❑ No	❑Yes
Diarrhea	❑ No	❑Yes
Constipation	❑ No	❑Yes
✪Heartburn/GERD	❑ No	❑Yes
Abdominal pain	❑ No	❑Yes
Stomach ulcers	❑ No	❑Yes
✪Hepatitis	❑ No	❑Yes
✪Diverticulitis	❑ No	❑Yes
✪Crohn's disease	❑ No	❑Yes
✪Ulcerative colitis	❑ No	❑Yes
Colon polyps	❑ No	❑Yes
✪Colon cancer	❑ No	❑Yes

URINARY SYSTEM

✪Prostate disease or cancer	❑ No	❑Yes
Blood in urine	❑ No	❑Yes
Painful urination	❑ No	❑Yes
Frequent urinary tract infection	❑ No	❑Yes
Kidney failure	❑ No	❑Yes

BLOOD/HEMATOLOGIC SYSTEM

Bruises easily	❑ No	❑Yes
✪Blood clots in legs	❑ No	❑Yes

ENDOCRINE

✪Thyroid disease	❑ No	❑Yes
✪Diabetes	❑ No	❑Yes
Heat intolerance	❑ No	❑Yes
Cold intolerance	❑ No	❑Yes
Adrenal disease	❑ No	❑Yes
Pituitary disease	❑ No	❑Yes

MUSCULOSKELETAL SYSTEM

Gout	❑ No	❑Yes
Osteoporosis	❑ No	❑Yes
Arthritis	❑ No	❑Yes
Back pain	❑ No	❑Yes

SKIN/INTEGUMENTARY SYSTEM

Rash	❑ No	❑Yes

NERVOUS SYSTEM

Frequent or recurring headaches	❑ No	❑Yes
Lightheaded or dizziness	❑ No	❑Yes
✪Stroke	❑ No	❑Yes
✪Seizures	❑ No	❑Yes
Neuropathy	❑ No	❑Yes

PSYCHIATRIC

✪Anxiety	❑ No	❑Yes
Depression	❑ No	❑Yes
Alcohol/drug withdrawal	❑ No	❑Yes

BREAST

Fibrocystic breasts	❑ No	❑Yes
✪Breast cancer	❑ No	❑Yes

OTHER

_____

_____

_____