



HEALTH HISTORY

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Please complete the information below to help you recall the information your doctor needs in evaluating your health.

Name _____ Date _____ Date of Birth _____

Why are you visiting the doctor: (Check one) General Check-up or Wellness Visit A particular problem

Do you feel that you are basically healthy? Yes No What is bothering you? _____

Family Health History

Member	Age	State of Health	Age at Death	Cause of Death or Poor Health
Father				
Mother				
Sisters				
Brothers				
Children				

Mark any diseases known to have occurred in the family with the appropriate initial: (M) Mother, (F) Father, GM (grandmother), GF (grandfather), A (aunt), U (uncle), C (cousin), B (brother), S (sister).

- | | | | |
|-------------------------------|------------------------------|---------------------------|--------------------|
| _____ Alzheimer | _____ Cancer | _____ Hearing Prob. | _____ Obesity |
| _____ Asthma | _____ Stroke | _____ Cholesterol | _____ Blood Clots |
| _____ Alcoholism | _____ Depression | _____ High Blood Pressure | _____ Kidney Prob. |
| _____ Blood Disease | _____ Developmental Problems | _____ Mental Disease | _____ Seizures |
| _____ Coronary Artery Disease | _____ Diabetes | _____ Migraines | _____ Sickle Cell |

About You:

Education: Elem. High School GED College Graduate School Tech School Trade School

Present Occupation _____ Single Married Widowed Divorced

Previous Occupation _____ Live with: Your Family Alone

Tobacco Use: Yes No Type _____ Amount _____ How Long _____

Alcohol Use: Yes No How much weekly? _____ Illicit drug use Yes No Please list _____

Allergies:

Medicines _____ Other _____

Medications: Please list medications you take regularly.

OVER THE COUNTER (Please include vitamins and supplements)

PRESCRIPTION

Your Health History

Serious Illnesses as a Child: Rheumatic Fever Kidney Trouble Prolonged Fever Heart Trouble Other

Serious Illnesses as an Adult: _____

OPERATIONS	TYPE OR CAUSE	WHEN AND WHERE

INJURIES	TYPE OR CAUSE	WHEN AND WHERE

Have you been in the hospital for anything other than surgeries? Yes No
 When and Where _____

Please mark "yes" to anything you have experienced recently or frequently in the past.

	Yes	No	When		Yes	No	When
Fever, chills, night sweats	<input type="checkbox"/>	<input type="checkbox"/>	_____	Vomit Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Severe or frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____	Recent change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	_____
Periods of unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Black bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	_____
Complete or partial blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blood in bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent indigestion or gas	<input type="checkbox"/>	<input type="checkbox"/>	_____
False teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ulcer of stomach or intestine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Feel anxious depressed Or irritable	<input type="checkbox"/>	<input type="checkbox"/>	_____	Burning when you pass urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hay fever or sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Goiter or thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____	Need to pass urine frequently	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____	Protein or albumin in urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nervous breakdown	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep with head elevated with 2 or more pillows	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fast, irregular or slow pulse	<input type="checkbox"/>	<input type="checkbox"/>	_____	Healthy appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain in chest	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sleep well	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Feel rested in the mornings	<input type="checkbox"/>	<input type="checkbox"/>	_____

Has your weight changed in the past year? Yes No How much? _____ Recent Weight _____
 Approximate weight 1 year ago _____ Approximate weight 5 years ago _____

For Women

Are you currently pregnant? Yes No Number of pregnancies ____ Miscarriages ____ Living children ____
 Age when menstrual periods began _____ Ended _____ Are periods regular Yes No
 Excess flow? Yes No Spotting between Periods Yes No