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?)

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

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

Associated signs/symptoms _____

_____
(What other associated problems have you been having?

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

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

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

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 "yes", leave blank if uncertain)

Measles	yes	Anemia	yes	Back trouble	yes	Hepatitis	yes
Mumps	yes	Bladder Infections	yes	High Blood Pressure	yes	Ulcer	yes
Chickenpox	yes	Epilepsy	yes	Low Blood Pressure	yes	Kidney Disease	yes
Whooping Cough	yes	Migraine Headaches	yes	Hemorrhoids	yes	Thyroid Disease	yes
Scarlet Fever	yes	Tuberculosis	yes	Date of last chest x-ray	____	Bleeding Tendency	yes
Diphtheria	yes	Diabetes	yes	Asthma	yes	Any other disease	yes
Smallpox	yes	Cancer	yes	Hives or Eczema	yes	(please list):	
Pneumonia	yes	Polio	yes	AIDS or HIV+	yes	_____	
Rheumatic Fever	yes	Glaucoma	yes	Infectious Mono	yes		
Heart Disease	yes	Hernia	yes	Bronchitis	yes	_____	
Arthritis	yes	Blood or Plasma		Mitral Valve Prolapse	yes		
Venereal Disease	yes	Transfusions	yes	Stroke	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 .... Yes
- Recent weight change ..... Yes
- Fever ..... Yes
- Fatigue ..... Yes
- Headaches ..... Yes

☐ **Eyes**
- Eye disease or injury ..... Yes
- Wear glasses/contact lenses ... Yes
- Blurred or double vision ..... Yes

☐ **Ears/Nose/Mouth/Throat**
- Hearing loss or ringing ..... Yes
- Earaches or drainage ..... Yes
- Chronic sinus problem or rhinitis Yes
- Nose bleeds ..... Yes
- Mouth sores ..... Yes
- Bleeding gums ..... Yes
- Bad breath or bad taste ..... Yes
- Sore throat or voice change ... Yes
- Swollen glands in neck ..... Yes

☐ **Cardiovascular**
- Heart trouble ..... Yes
- Chest pain or angina pectoris .. Yes
- Palpitation ..... Yes
- Shortness of breath w/walking or lying flat ..... Yes
- Swelling of feet, ankles or hands Yes

☐ **Respiratory**
- Do you have a persistent cough or throat clearing not associated with a known illness (lasting mor than 3 weeks)? ..... Yes
- Spitting up blood ..... Yes
- Shortness of breath ..... Yes
- Wheezing ..... Yes

☐ **Gastrointestinal**
- Loss of appetite ..... Yes
- Change in bowel movements .. Yes
- Nausea or vomiting ..... Yes
- Frequent diarrhea ..... Yes
- Painful bowel movements or constipation ..... Yes
- Rectal bleeding or blood in stool Yes
- Abdominal pain ..... Yes

☐ **Genitourinary**
- Frequent urination ..... Yes
- Burning or painful urination .... Yes
- Blood in urine ..... Yes
- Change in force of strain when urinating ..... Yes
- Incontinence or dribbling ..... Yes
- Kidney stones ..... Yes
- Sexual difficulty ..... Yes
- Male - testicle pain ..... Yes
- Female - pain with periods .... Yes
- Female - irregular periods ..... Yes
- Female - vaginal discharge ..... Yes
- Female - # of pregnancies .... _____
- Female - # of miscarriages .... _____
- Female - date of last pap smear _____

☐ **Musculoskeletal**
- Joint pain ..... Yes
- Joint stiffness or swelling ..... Yes
- Weakness of muscles or joints .. Yes
- Muscle pain or cramps ..... Yes
- Back pain ..... Yes
- Cold extremities ..... Yes
- Difficulty in walking ..... Yes

☐ **Integumentary (skin, breast)**
- Rash or itching ..... Yes
- Change in skin color ..... Yes
- Change in hair or nails ..... Yes
- Varicose veins ..... Yes
- Breast pain ..... Yes
- Breast lump ..... Yes
- Breast discharge ..... Yes

☐ **Neurological**
- Frequent or recurring headaches Yes
- Light headed or dizzy ..... Yes
- Convulsions or seizures ..... Yes
- Numbness or tingling sensations Yes
- Tremors ..... Yes
- Paralysis ..... Yes
- Head injury ..... Yes

☐ **Psychiatric**
- Memory loss or confusion ..... Yes
- Nervousness ..... Yes
- Depression ..... Yes
- Insomnia ..... Yes

☐ **Endocrine**
- Glandular or hormone problem Yes
- Excessive thirst or urination .... Yes
- Heat or cold intolerance ..... Yes
- Skin becoming dryer ..... Yes
- Change in hat or glove size .... Yes

☐ **Hematologic/Lymphatic**
- Slow to heal after cuts ..... Yes
- Bleeding or bruising tendency .. Yes
- Anemia ..... Yes
- Phlebitis ..... Yes
- Past transfusion ..... Yes
- Enlarged glands ..... Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics . Yes
- Morphine, Demerol, or other narcotics ..... Yes
- Novocain or other anesthetics Yes
- Aspirin or other pain remedies Yes
- Tetanus antitoxin or other serums ..... Yes
- Iodine, Merthiolate or other antiseptic ..... 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