HEALTH HISTORY

Name ____ Today's Date ___________

Age: ______ Birth Date: ____________ Reason for today's visit: ____

SYMPTOMS Check symptoms that you currently have or have had in the last 6 to 12 months. Chronic problems are on the next page.

Constitutional / Emotional
- ☐ Fever/ Chills
- ☐ Depression
- ☐ Anxiety
- ☐ Dizzy/ fainting
- ☐ Memory Fog
- ☐ Sleep, falling to
- ☐ Sleep, interrupt
- ☐ Weight gain
- ☐ Weight loss

Muscle & Joint
- ☐ Finger joint pain
- ☐ Knee pain
- ☐ Hip pain
- ☐ Arm pain
- ☐ Muscle pain
- ☐ Falls, unsteady
- ☐ Weakness
- ☐ Neck / back pain

Neurologic
- ☐ Migraines
- ☐ Headache, other
- ☐ Weakness
- ☐ Numbness

Gastrointestinal
- ☐ Heartburn/reflux
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Gas or bloating
- ☐ Carb cravings

Endocrine
- ☐ Tired/ fatigued
- ☐ Excessive thirst
- ☐ Urinating > 3x/night
- ☐ Foot or hand pain
- ☐ Foot or hand numbness

Heart
- ☐ High blood pressure
- ☐ Palpitations
- ☐ Arrhythmia

Hematologic
- ☐ Blood disorder
- ☐ Lymph edema

Lungs
- ☐ Short of breath
- ☐ Difficulty breathing
- ☐ Chronic cough
- ☐ Asthma

Ears/Nose/Mouth
- ☐ Ear pain
- ☐ Tinnitus
- ☐ Throat pain
- ☐ Sinuses
- ☐ Hoarseness

Eyes
- ☐ Single eye sight
- ☐ Double vision
- ☐ Blurred vision
- ☐ Loss of visual field

Genito-urinary
- ☐ Urine incontinence
- ☐ Blood in urine

Skin
- ☐ Rash
- ☐ Changing moles
- ☐ Breast lump
- ☐ Discharge or sores
- ☐ Eczema/ Psoriasis

Women Only
- ☐ PMS
- ☐ Menstrual cramps
- ☐ Heavy periods
- ☐ Painful periods
- ☐ Irregular periods
- ☐ Spotting
- ☐ Hot flashes
- ☐ Painful intercourse
- ☐ Vaginal discharge

First day of last Menses ___________

Date and result of last PAP___________

# of children ________

Pregnant? _________

Men only
- ☐ Erection problem
- ☐ Prostate
- ☐ Testicle
- ☐ Discharge or sores

Additional comments ____

____

MEDICINES and SUPPLEMENTS:			ALLERGIES to meds, latex
Pharmacy name, street & city:			

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Name ____ Today's Date ___________

Check conditions that you have or have had:

- ☐ Heart attack, heart dz
- ☐ Stroke or TIA
- ☐ Diabetes
- ☐ Seizures
- ☐ Emphysema, COPD
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Hypertrhyroidism
- ☐ Stomach ulcer
- ☐ Crohn's/ colitis
- ☐ Chronic fatigue synd
- ☐ Fibromyalgia
- ☐ Lymes
- ☐ Auto immune prob
- ☐ HIV + or AIDS
- ☐ Gall stones
- ☐ Kidney stones
- ☐ Hernia, any kind
- ☐ Kidney failure
- ☐ Liver disease
- ☐ Insomnia, severe
- ☐ Cancer
- ☐ Breast biopsy
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Chronic pain
- ☐ Migraine headaches
- ☐ Osteopenia/ porosis
- ☐ Anemia
- ☐ Blood disorder
- ☐ Rheumatic fever
- ☐ Glaucoma, cataract
- ☐ Eating disorder
- ☐ Alcoholism
- ☐ Drug addiction
- ☐ Other

Year	**Hospitalizations, surgeries, serious illness or injury**	**Pregnancy History**		
		Year	Sex	Comments
		☐	Coffee	
		☐	High stress	
Health Habits		☐	Nicotine	
Exercise:		☐	Recreational drugs	
Diet:		Occupation:		

FAMILY HISTORY: Fill in health information about your mother, father, siblings and children:

Relation	Age	Health status or age and cause of death	Family Health Problems		Relationship to you
Father			☐	Cancer	
Mother			☐	Arthritis	
Siblings			☐	Diabetes	
			☐	ADD or ADHD	
			☐	Crohn's or Colitis	
			☐	Other	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or her staff responsible for any errors or omissions.

Patient or Patient's Guardian ____ Date _____________

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