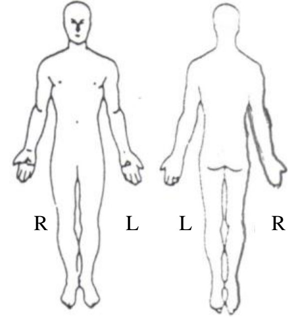
HEALTH HISTORY **Date:** ______________________________

Patient Name: ____ Birth date: __________________ Age: _________________

Chief Complaint/Reason for visit: ____



History of present illness **Mark location of your pain on diagram** ⟶

Location: ____________________________________ (Where is the pain/problem?)

Quality: DULL SHARP THROB ACHE (CIRCLE)

Severity: No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain (Circle your level of pain)

Duration: __________ (How long you have had problem)

Timing: ______________________________________ (Does the pain/problem occur at specific times?)

Context: __________________________ (Where were you at the onset of pain/problem?)

Associated Signs/symptoms: ______________________ ____ (What other associated problems have you been having?)

Modifying factors: ___________________________________ ____ What makes the symptoms worse or better? Or, have you had previous episodes?

Past Medical History: **Please check if you have had any of the following:**

- ☐ Measles
- ☐ Mumps
- ☐ Chicken pox
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Smallpox
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Venereal Disease
- ☐ Anemia
- ☐ Bladder Infections
- ☐ Epilepsy
- ☐ Migraine Headaches
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Cancer
- ☐ Polio
- ☐ Glaucoma
- ☐ Hernia
- ☐ Blood Transfusion
- ☐ Plasma Transfusion
- ☐ Back Trouble
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Hemorrhoids
- ☐ Chest x-ray – Date:
- ☐ Asthma
- ☐ Hives or Eczema
- ☐ AIDS or HIV+
- ☐ Infectious Mono
- ☐ Bronchitis
- ☐ Mitral Valve Prolapse
- ☐ Stroke
- ☐ Hepatitis
- ☐ Ulcer
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Bleeding Tendency
- ☐ Other Diseases – Please List

Do you have an advance directive for healthcare? YES NO

Previous Hospitalizations/Surgeries/Serious Illnesses	When	Where

Medications	Dosage	How Taken and Reason

Patient Social History: (Circle correct response) **Occupation:** ____

Marital Status:	Single	Married	Separated	Divorced	Widowed
Use of Alcohol:	Never	Rarely	Moderate	Daily	
Use of tobacco:	Never	Previously, quit: _______________		Current Packs/day: ___________________	
Use of drugs:	Never	Previously, quit: _______________		Type/Frequency: _____________________	
Excessive exposure to:	Fumes	Dust	Solvents	Air borne particles	Noise

Allergies to Medications/Other: YES NO YOUR PREFERRED PHARMACY NAME/PHONE: ___________________________________

If yes, please list allergies: ____

PLEASE COMPLETE OTHER SIDE

NAME: ______________________________ DATE: ______________________

Family Medical History	Age	Diseases/Illnesses	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Review of Symptoms: Please check any personal history below:

GENERAL

- [ ] Chills
- [ ] Depression
- [ ] Dizziness
- [ ] Fainting
- [ ] Fever
- [ ] Forgetfulness
- [ ] Headache
- [ ] Loss of Sleep
- [ ] Loss of Weight
- [ ] Nervousness
- [ ] Numbness
- [ ] Sweats

MUSCLE/JOINT/BONE

- [ ] Pain, weakness, or numbness in:
- [ ] Arms
- [ ] Back
- [ ] Feet
- [ ] Hands
- [ ] Hips
- [ ] Legs
- [ ] Neck
- [ ] Shoulders

GENITO-URINARY

- [ ] Blood in urine
- [ ] Frequent urination
- [ ] Lack of bladder control
- [ ] Painful urination

GASTROINTESTINAL

- [ ] Appetite poor
- [ ] Bloating
- [ ] Bowel changes
- [ ] Constipation
- [ ] Diarrhea
- [ ] Excessive thirst
- [ ] Gas
- [ ] Hemorrhoids
- [ ] Indigestion
- [ ] Nausea
- [ ] Rectal bleeding
- [ ] Stomach pain
- [ ] Vomiting
- [ ] Vomiting blood

CARDIO/RESPIRATORY

- [ ] Chest pain
- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Irregular heart beat
- [ ] Poor circulation
- [ ] Rapid heart beat
- [ ] Swelling of ankles
- [ ] Varicose veins
- [ ] Shortness of Breath

NUTRITION

- [ ] Swallowing Problems
- [ ] Appetite Problems
- [ ] Taking nutritional supplements
- [ ] Significant weight gain/loss

EYE, EAR, NOSE, & THROAT

- [ ] Bleeding gums
- [ ] Blurred vision
- [ ] Crossed eyes
- [ ] Difficulty swallowing
- [ ] Double Vision
- [ ] Earache
- [ ] Ear discharge
- [ ] Hay Fever
- [ ] Hoarseness
- [ ] Loss of hearing
- [ ] Nosebleeds
- [ ] Persistent cough
- [ ] Ringing in ears
- [ ] Sinus problems
- [ ] Vision-Flashes
- [ ] Vision-Halos

SKIN

- [ ] Bruise easily
- [ ] Hives
- [ ] Itching
- [ ] Change in moles
- [ ] Rash
- [ ] Scars
- [ ] Sores that won't heal

MEN only

- [ ] Breast lump
- [ ] Erection difficulties
- [ ] Lump in testicles
- [ ] Penis discharge
- [ ] Sore on penis
- [ ] Other

WOMEN only

- [ ] Abnormal pap smear
- [ ] Bleeding between periods
- [ ] Breast lump
- [ ] Extreme menstrual pain
- [ ] Hot flashes
- [ ] Nipple discharge
- [ ] Painful intercourse
- [ ] Vaginal discharge
- [ ] Other
- [ ] Date of last menstruation:
- [ ] Date of last pap smear:
- [ ] Are you pregnant? YES NO
- [ ] Number of children:

PSYCHIATRIC

- [ ] Depression
- [ ] Anxiety, panic attacks, or phobias
- [ ] Difficulty coping with stress
- [ ] Any suicidal thoughts

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 responsibility to inform the doctor's office of any changes in my medical status. I also consent to treatment by this facility.

______________________________ ______________________

Signature of patient, parent, or guardian — Date

______________________________ ______________________

Signature of Physician — Date

Signature above confirms all items have been reviewed, unchecked items are non-contributory.