Patient Health History

Patient Name: ______________________________

Date: _____ / _____ / _____ Age: ________ DOB:_____ / _____ / _____

Date of last physical examination: ______________________________

What is your reason for visit? ______________________________

____

SYMPTOMS

GENERAL
- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Sweats

EYES
- ❑ Crossed eyes
- ❑ Double vision
- ❑ Vision - Flashes
- ❑ Vision - Halos
- ❑ Blurred vision

EARS/NOSE/THROAT
- ❑ Earache
- ❑ Ear Discharge
- ❑ Ringing in ears
- ❑ Loss of hearing
- ❑ Hay fever
- ❑ Sinus problem
- ❑ Nose bleeds
- ❑ Bleeding gums
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Persistent cough

RESPIRATORY
- ❑ Shortness of breath
- ❑ Cough
- ❑ Congestion
- ❑ Distress
- ❑ Sputum

GENITO-URINARY
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

ENDOCRINE
- ❑ Weight gain
- ❑ Weight loss
- ❑ Hoarseness
- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Breast Changes
- ❑ Hair Changes
- ❑ Extreme Thirst

GASTROINTESTINAL
- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting - no blood
- ❑ Vomiting - bleeding

CARDIOVASCULAR
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

WOMEN ONLY
- ❑ Abnormal Pap Smear
- ❑ Bleeding between periods
- ❑ Breast lumps
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipples discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other

Date of last menstrual period ________________

Date of last Pap Smear ________________

Have you had a mammogram?
❑ Yes ❑ No

Are you pregnant?
❑ Yes ❑ No

Number of children ________

- ❑ Breast lumps

MEN ONLY
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other ____________

INTEGUMENTARY
- ❑ Bruise easy
- ❑ Hives
- ❑ Change in moles
- ❑ Sores that wont heal
- ❑ Itching
- ❑ Unusual swelling
- ❑ Sores/ulcers
- ❑ Rash
- ❑ Scars

NEUROLOGICAL
- ❑ Seizures
- ❑ Vertigo
- ❑ Dizziness
- ❑ Hand Trembling
- ❑ Loss of Sensations
- ❑ Loss of facial expression
- ❑ Weak Grip
- ❑ Paralysis
- ❑ Difficulty of Speech
- ❑ Tingling
- ❑ Loss of Memory
- ❑ Numbness
- ❑ Un-coordination

MUSCLE/JOINT/BONE
- ❑ Arms
- ❑ Hips
- ❑ Back
- ❑ Legs
- ❑ Feet
- ❑ Neck
- ❑ Hands
- ❑ Shoulders

PSYCHIATRIC
- ❑ Hyperventilation
- ❑ Insecurity
- ❑ Depression
- ❑ Trouble Sleeping
- ❑ Irritable
- ❑ Anxiousness
- ❑ Undecidedness
- ❑ Timid
- ❑ Hallucinations
- ❑ Loss of Memory
- ❑ Alcoholism
- ❑ Drug Addiction
- ❑ Drug Dependency
- ❑ Extreme Worry
- ❑ Sexual Problems
- ❑ Suicidal Thoughts

CONDITIONS
- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lumps
- ❑ Bronchitis
- ❑ Breath shortness
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease
- ❑ Other ____________

MEDICATIONS List medications you are currently taking and dosage	**ALLERGIES** to medications or substances

Patient/Guardian Signature: ______________________________ Date: _____ / _____ / _____