Health History

Patient Name _____ Date _____
Student ID# _____ DOB _____ Age _____
Gender: Male / Female / Transgender / Decline to state Ethnicity _____
Health Insurance: Yes or No, **if yes:** Private / Medi-Cal / Family Pact / Medicare (for Seniors) / Unsure
Cell/Contact # _____ E-mail address _____

Past Medical History

Have you ever had the following: **(Circle "No" or "Yes", leave blank if uncertain)**

Blood Transfusion	No Yes	Anemia	No Yes	Heart Disease/Stroke	No Yes	Pneumonia	No Yes
Arthritis	No Yes	Epilepsy/Seizures	No Yes	High Blood Pressure	No Yes	Sickle Cell Disease	No Yes
AIDS/HIV +	No Yes	Tuberculosis	No Yes	Low Blood Pressure	No Yes	Stomach Ulcer	No Yes
Chlamydia	No Yes	Diabetes	No Yes	Hives or Eczema	No Yes	Kidney Disease	No Yes
Gonorrhea	No Yes	Cancer	No Yes	Asthma	No Yes	Thyroid Disorder	No Yes
HPV/Abnl PAP	No Yes	Mitral Valve Prolapse	No Yes	History of (+) PPD	No Yes	Date of last chest x-ray	_____
Syphilis	No Yes	Any other disease	No Yes	_____			
Malaria	No Yes	Did you receive your childhood vaccines?	No Yes	Up to date?	No Yes Unsure		
Hepatitis	No Yes						

Previous Hospitalizations & ER visits/ Surgeries/ Cosmetic Surgeries **Date**

_____ _____ _____
_____ _____ _____

Medications: (Include: Prescription & Inhalers, Nonprescription, Birth Control methods, Vitamins)

_____
_____

Patient social history:

Marital Status:	Single:	_____	Married:	_____	Widow:	_____	Divorced: _____
Use of alcohol:	Never:	_____	Rarely:	_____	Moderate:	_____	Quit: _____
Use of tobacco:	Never:	_____	Previously, but quit:	_____	Current packs/day:		_____
Use of drugs:	Never:	_____	Frequency:	_____	Type:	_____	Quit: _____
Exercise:	Never:		Rarely:	_____	Moderate:	_____	Daily: _____
Caffeine use:	Cups/sodas per day	_____					
Work Type:	Part time / Full time / Full time student / Other:	_____					

***Family Background:** Have Parents, Siblings, Grand parents had any of the following?

* Maternal / Paternal / Deceased

Yes	No	Medical Problem	Relation & Dates
		Cancer / Leukemia / Type	
		High Cholesterol / High Blood Pressure	
		Diabetes	
		Heart Disease / Stroke	
		Thyroid Disorder / Lupus	
		Alcoholism / Drug Abuse	
		Mental Illness / Depression / Suicide	
		Other Serious Illness / Disorder	

Review of systems: Please indicate any CURRENT concerns that you are experiencing below:

Constitutional Symptoms:
Good general health lately.... No Yes
Recent weight change..... No Yes
Fever..... No Yes

Eyes:
Eye disease or injury..... No Yes
Wear glasses/contacts..... No Yes
Glaucoma/cataracts..... No Yes
Blurred or double vision..... No Yes

Ears/Nose/Mouth/Throat:
Hearing loss or ringing..... No Yes
Earaches or drainage..... No Yes
Chronic sinus problem
or Allergies..... No Yes
Nose bleeds..... No Yes
Mouth sores..... No Yes
Bleeding gums..... No Yes
Sore throat or voice change... No Yes
Swollen glands in neck..... No Yes
Goiter..... No Yes

Cardiovascular:
Heart trouble..... No Yes
Chest pain/Angina pectoris.... No Yes
Palpitations/Irregular
heartbeat..... No Yes
Shortness of breath w/
walking or lying flat..... No Yes
Swelling of feet, ankles,
or hands..... No Yes
Heart murmur (Diagnosed)... No Yes

Respiratory:
Chronic or frequent coughs... No Yes
Spitting up blood..... No Yes
Shortness of breath..... No Yes
Wheezing..... No Yes
Emphysema..... No Yes

Gastrointestinal:
Loss of appetite..... No Yes
Change in bowel movements. No Yes
Nausea or vomiting..... No Yes
Frequent diarrhea..... No Yes
Painful bowel movents
or Constipation..... No Yes
Rectal bleeding or Blood in
stool/Hemorrhoids..... No Yes
Abdominal pain..... No Yes

Genitourinary:
Frequent urination..... No Yes
Burning or Painful urination.. No Yes
Blood in urine..... No Yes
Kidney stones..... No Yes
Sexual difficulty..... No Yes
Male - Testicle pain..... No Yes
Female-Pain with periods..... No Yes
Female-Irregular periods..... No Yes
Female-Vaginal discharge..... No Yes
Female-# of Pregnancies..... _____
Female-# of Deliveries..... _____
Female-Date of last Pap
Smear/STD testing..... _____
Uterine Fibroids..... No Yes
Ovarian Cysts..... No Yes

Musculoskeletal:
Joint pain..... No Yes
Joint stiffness or swelling..... No Yes
Weakness of muscles
or joints..... No Yes
Back pain..... No Yes
Cold extremities..... No Yes
Difficulty walking..... No Yes
Gout..... No Yes

Integumentary (skin, breast):
Change in mole..... No Yes
Rash or itching..... No Yes
Change in skin color..... No Yes
Change in hair color..... No Yes
Varicose veins..... No Yes
Breast pain/Discharge..... No Yes
Breast Implants..... No Yes
Breast lump..... No Yes
Date of last mammography/ultrasound
_____

Psychiatric:
ADD/ADHD symptoms..... No Yes
Past suicide attempts..... No Yes
Memory loss or confusion..... No Yes
Nervousness..... No Yes
Depression..... No Yes
Insomnia..... No Yes

Neurological:
Frequent or recurring
headaches..... No Yes
Light headed or dizzy..... No Yes
Numbness or tingling
sensation..... No Yes
Tremors..... No Yes
Paralysis..... No Yes
Head injury/Concussion..... No Yes

Endocrine:
Glandular or hormone
problem..... No Yes
Excessive thirst or urination... No Yes
Heat or cold intolerance..... No Yes
Skin becoming dryer..... No Yes
Hair loss..... No Yes

Hemotologic/Lymphatic:
Slow to heal after cuts..... No Yes
Bleeding or bruising
tendency..... No Yes
Phlebitis/Blood clot..... No Yes
Enlarged glands..... No Yes

Allergic to medicine:
_____
_____

Please circle allergic symptoms:
Anaphylaxis/Rash/Swelling of throat/
Lips or shortness of breath

Latex Allergy..... No Yes
Adhesive Allergy..... No Yes

Environmental & food allergies:
_____
_____

Provider's Review: _____

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 change in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Patient's Signature _____ Date _____ Provider's Signature _____ Date _____