



Health History

Patient Name _____ Date _____
 Student ID# _____ Birth date _____ Age _____ Gender: M/F

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles.....	No	Yes	Anemia.....	No	Yes	Back Trouble.....	No	Yes	Hepatitis.....	No	Yes
Mumps.....	No	Yes	Bladder infections	No	Yes	High Blood Pressure...	No	Yes	Ulcer.....	No	Yes
Chickenpox.....	No	Yes	Epilepsy.....	No	Yes	Low Blood Pressure...	No	Yes	Kidney Disease...	No	Yes
Whooping Cough	No	Yes	Migraines.....	No	Yes	Hemorrhoids.....	No	Yes	Thyroid Disease....	No	Yes
Scarlet Fever.....	No	Yes	Tuberculosis.....	No	Yes	Date of last chest x-ray	_____				
Diphtheria	No	Yes	Diabetes.....	No	Yes	Asthma.....	No	Yes	Any other disease	No	Yes
Smallpox.....	No	Yes	Cancer.....	No	Yes	Hives or Eczema.....	No	Yes	_____		
Pneumonia.....	No	Yes	Polio.....	No	Yes	AIDS or HIV +	No	Yes	_____		
Heart Disease.....	No	Yes	Hernia.....	No	Yes	Bronchitis.....	No	Yes	_____		
Arthritis.....	No	Yes	Blood or Plasma			Mitral Valve Prolapse	No	Yes	_____		
Venereal Disease..	No	Yes	Transfusions.....	No	Yes	Stroke.....	No	Yes	_____		

Did you receive your childhood vaccines? No Yes Unsure

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription) _____

Patient social history:

Marital Status Single: _____ Married: _____ Widow: _____ Divorced: _____
 Use of alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
 Use of tobacco: Never: _____ Previously, but quit: _____ Current packs/day: _____
 Use of drugs: Never: _____ Type/Frequency: _____
 Number of caffeine cups/day _____
 Exercise: Never: _____ Rarely: _____ Moderate: _____ Daily: _____
 Occupation: _____

Family Background: Has anyone in your Family/Blood Relatives had any of the following?

Yes	No	Medical Problem	Relation & Dates
		Cancer	
		High Cholesterol	
		Diabetes	
		High Blood Pressure	
		Heart Disease	
		Alcoholism / Drug abuse	
		Stroke	
		Other	

Review of systems: Please indicate any personal history in the last 6 months below:

▪ **Constitutional Symptoms**

Good general Health lately... No Yes
 Recent weight change..... No Yes
 Fever..... No Yes
 Headache..... 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
 Palpitation..... No Yes
 Shortness of breath w/
 walking or lying flat..... No Yes
 Swelling of feet, ankles,
 or hands..... No Yes
 Heart murmur..... 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 movements
 or constipation..... No Yes

Rectal bleeding or blood in
 stool..... 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 miscarriages.... _____
 Female- date of last pap
 smear..... _____
 Incontinence..... No Yes
 Postmenopausal bleeding... 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 in 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..... No Yes
 Breast discharge..... No Yes
 Breast lump..... No Yes
 Date of last mammography _____

▪ **Psychiatric**

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
 Convulsions..... No Yes
 Numbness or tingling
 sensation..... No Yes
 Tremors No Yes
 Paralysis..... No Yes
 Head injury..... 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
 Excessive Sweating..... No Yes

▪ **Hematologic/Lymphatic**

Slow to heal after cuts No Yes
 Bleeding or bruising
 tendency No Yes
 Anemia..... No Yes
 Phlebitis..... No Yes
 Past transfusion..... No Yes
 Enlarged glands..... No Yes

▪ **Allergic/Immunologic**

History of skin reaction or other
 adverse reaction to: _____

 Known food allergies _____

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

Patient Signature _____

Date _____

Provider's signature _____

Date _____