



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 CURRENT concerns that you are experiencing 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 _____