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# HEALTH HISTORY

Name _____ Date _____DOB _____

**MEDICATIONS**
List all current medications (prescription and nonprescription drugs), herbs and supplements with dosages.

_____
_____
_____
_____

**ALLERGIES**
List any allergies you have to drugs, food or environmental agents. Please indicate what type of reaction you have.

_____
_____

**CHILDHOOD HEALTH**
Generally described as (please circle) Good Fair Poor

Please indicate which, if any, of the following illnesses you have had.

| | | | |
|---|---|---|---|
| Asthma | German measles | Mumps | Whooping cough |
| Scarlet fever | Hepatitis | Chicken pox | Rheumatic fever |
| Diphtheria | Measles | | |

Vaccinations: (year, type, adverse reactions?) _____
_____

**HABITS/LIFESTYLE**
Please circle and/or give a brief description where indicated
Alcohol: How much?_____ How often? _____
Tobacco: Type: smoke or chew How long used? _____
Caffeine: How much? _____
Recreational drugs: How much?_____How long used? _____
Diet restrictions _____

Food cravings _____

Exercise program_____

Average hours of sleep _____ Do you wake rested? Yes/No

Do you sleep well?_____

Occupation_____ Do you like your job? Yes/No

Stress level (home/job/other)_____

Living situation (house/apt, number in household, etc.)_____

_____

Single/Committed relationship/Married/Divorced (please circle the situation that applies to you)

Social life/activities_____

Spiritual practice _____

**FAMILY HISTORY**

Fill in all that apply

| | Father | Mother | Brother(s) | Sister(s) | Spouse | Other |
|---|---|---|---|---|---|---|
| Age (if living) | | | | | | |
| Age at death | | | | | | |
| General health | | | | | | |
| Alcoholism | | | | | | |
| Allergies | | | | | | |
| Anemia | | | | | | |
| Asthma | | | | | | |
| Cancer | | | | | | |
| Diabetes | | | | | | |
| Epilepsy | | | | | | |
| Glaucoma | | | | | | |
| Heart disease | | | | | | |
| Hepatitis | | | | | | |
| High blood pressure | | | | | | |
| Kidney disease | | | | | | |
| Mental illness | | | | | | |
| Stroke | | | | | | |
| Tuberculosis | | | | | | |
| Other (describe) | | | | | | |
| Other (describe) | | | | | | |

**PERSONAL HISTORY**

Circle any of the following illness that you have had.

| | | |
|---|---|---|
| Mononucleosis | Asthma | Stomach ulcer |
| Rheumatic fever | Frequent lung infections | Colitis |
| Angina pectoris | Emphysema | Gallbladder disease |
| Heart attack | Diabetes | Jaundice |
| Other heart disease | Tuberculosis | Hepatitis |
| High blood pressure | Cancer | Arthritis |
| Kidney disease | Freq kidney/bladder infections | Migraine headache |
| Gout | Nervous breakdown | Thyroid disease |
| Anemia | Depression | Sexually transmitted disease |
| Hay fever | Alcoholism | HIV or AIDS |

Other _____

List all operations and approximate date _____

_____

_____

List all hospitalizations (other than operations) with reason admitted and approximate date

_____

_____

List all serious injuries (other than above) with approximate date _____

_____

_____

**GENERAL HEALTH**

Date of last physical exam _____ dental exam _____ eye exam _____
Weight _____ Weight 1 year ago _____
Height_____

**REVIEW OF SYSTEMS**

Circle which, if any, of the following symptoms you currently have.

| | | |
|---|---|---|
| Dizziness | Persistent hoarseness | Black or tarry stool |
| Fatigue | Lump in the throat | Nausea |
| Fever | Sore tongue or mouth | Bloating/gas |
| Weight loss or gain (unexplained) | Bleeding gums | Rectal pain |
| Swollen glands | Dental problems | Frequent urination |
| Insomnia | Frequent chest colds | Large amount of urine |
| Anxiety/depression | Persistent cough | Pain with urination |
| Appetite or thirst changes | Coughing up blood | Urinate at night |
| Night sweats | Short of breath | Trouble urinating |
| Cold hands/feet | Short of breath at night | Dribbling urine |
| Itching | Irregular heart beat | Lose urine when coughing |
| Rashes | Chest pain/tightness | Genital sores |
| Skin growths | Swelling feet/ankles | Genital discharge |
| Slow wound healing | Easy bruising | Pain during intercourse |
| Headache | Blood clots/phlebitis | Memory changes |
| Hair loss/weak nails | Abdominal discomfort | Seizures |
| Eye pain | Burping | Fainting |
| Vision changes | Difficulty swallowing | Coordination changes |
| Hearing changes | Indigestion/heartburn | Changes in strength |
| Ringing/buzzing in ear | Vomiting blood | Numbness/tingling |
| Earaches/discharge | Constipation | Neck/back pain |
| Nasal discharge | Diarrhea/loose stools | Muscle pain |
| Nosebleeds | Change in bowel habit | Joint pain |
| Sinus problems | Hemorrhoids | |
| Frequent sore throats | Bleeding from rectum | |

**For women only**

Age menses began _____ Last menstrual period _____
Length of menses _____ Number of pregnancies_____
Type of birth control used _____ Number of abortions _____
Type of STD protection used_____ Number of miscarriages _____
Last breast exam/pap _____ Normal? If not, describe_____

Circle which, if any, of the following symptoms you currently have

| | | |
|---|---|---|
| Vaginal discharge | Heavy menses | Breast lumps |
| Pain with intercourse | Missed menses | Breast tenderness |
| Painful menses | Bleed btwn menses | Nipple discharge |

**For men only**

Date of last prostate exam_____ Normal? If not, describe _____
Type of birth control used _____
Type of STD protection used_____