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HEALTH HISTORY

Please Print Clearly in Black or Blue Ink

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 _____