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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: 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 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?

Do you sleep well? ____________________

Occupation ____ Do you like your job?

Stress level (home/job/other) ____

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

____

Relationship Status: Single Committed Relationship Married Divorced

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
Rheumatic fever
Angina pectoris
Heart attack
Other heart disease
High blood pressure
Kidney disease
Gout
Anemia
Hay fever

Asthma
Frequent lung infections
Emphysema
Diabetes
Tuberculosis
Cancer
Freq kidney/bladder infections
Nervous breakdown
Depression
Alcoholism

Stomach ulcer
Colitis
Gallbladder disease
Jaundice
Hepatitis
Arthritis
Migraine headache
Thyroid disease
Sexually transmitted disease
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 _________