HEALTH HISTORY

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Office Use

Name ________________________ Date __________ Date of Birth ____________

Why are you visiting the doctor: ________________________________

FAMILY HEALTH HISTORY
Mark any diseases known to have occurred in the family with the appropriate initial: (**M**) Mother, (**F**) Father, **GM** (grandmother), **GF** (grandfather), **S** (sibling).

______ Alzheimer	______ Cancer	_____ Hearing Problems	_____ Obesity
______ Asthma	______ Stroke	_____ Cholesterol	_____ Blood Clots
______ Alcoholism	______ Depression	_____ High Blood Pressure	_____ Kidney Problems
______ Blood Disease	______ Developmental Problems	_____ Mental Disease	_____ Seizures
______ Coronary Artery Disease	_____ Diabetes	_____ Migraines	_____ Sickle Cell

ABOUT YOU:

Tobacco Use: ☐Current Smoker-Everyday (indicate how much) ________ ☐Current Smoker-occasional__________

☐Former Smoker ☐Never Smoked ☐Smoker-current status unknown ☐Unknown if ever smoked

Alcohol Use: ☐ Yes ☐ No How much weekly? __________ Illicit drug use ☐ Yes ☐ No Please list ______________

ALLERGIES: Medicines ______________________________ Other__________________________

MEDICATIONS*: (Including over the counter medications such as vitamins or supplements taken daily)*

____

____

Serious Illnesses: ☐ Rheumatic Fever ☐ Kidney Trouble ☐ Prolonged Fever ☐ Heart Trouble ☐ Other ________

Have you ever been hospitalized? ☐ Yes ☐ No

When and Where____

General	Yes	No	When
Feel anxious, depressed Or irritable	☐	☐	_______
Nervous breakdown	☐	☐	_______
Fever, chills, night sweats	☐	☐	_______
Skin			
Skin rashes	☐	☐	_______
Eyes, Ears, Nose, Throat			
Severe or frequent headaches	☐	☐	_______
Hearing trouble	☐	☐	_______
Goiter or thyroid trouble	☐	☐	_______
Vision trouble	☐	☐	_______
Respiratory			
Shortness of breath	☐	☐	_______
Asthma	☐	☐	_______
Cough	☐	☐	_______

Cardiovascular	Yes	No	When
Heart trouble	☐	☐	_______
Pain in chest	☐	☐	_______
Gastrointestinal			
Recent change in bowel habits	☐	☐	_______
Diarrhea	☐	☐	_______
Frequent indigestion or gas	☐	☐	_______
Genitourinary			
Blood in urine	☐	☐	_______
Burning when you pass urine	☐	☐	_______
Sexually transmitted disease	☐	☐	_______
Musculoskeletal			
Arthritis	☐	☐	_______

Health Changes __________________

Has your weight changed in the past year?

☐ Yes ☐ No

Approximate weight 1 year ago _______________

For Women

Are you currently pregnant? ☐ Yes ☐ No Are periods regular ☐ Yes ☐ No

Excess flow? ☐ Yes ☐ No Spotting between Periods ☐ Yes ☐ No

Patient Signature ________________________________ Date ______________