

# HEALTH HISTORY

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

## PAST MEDICAL HISTORY (check conditions that you have been diagnosed with)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> high blood pressure  | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> anemia               | <input type="checkbox"/> goiter             |
| <input type="checkbox"/> heart disease        | <input type="checkbox"/> ulcers                | <input type="checkbox"/> osteoarthritis       | <input type="checkbox"/> stroke             |
| <input type="checkbox"/> heart failure        | <input type="checkbox"/> hiatal hernia         | <input type="checkbox"/> osteoporosis         | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> glaucoma              | <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> tuberculosis       |
| <input type="checkbox"/> pacemaker            | <input type="checkbox"/> cataracts             | <input type="checkbox"/> psychiatric care     | <input type="checkbox"/> epilepsy           |
| <input type="checkbox"/> high cholesterol     | <input type="checkbox"/> kidney disease        | <input type="checkbox"/> alcoholism           | <input type="checkbox"/> migraine headaches |
| <input type="checkbox"/> asthma               | <input type="checkbox"/> liver disease         | <input type="checkbox"/> prostate problems    | <input type="checkbox"/> AIDS               |
| <input type="checkbox"/> emphysema            | <input type="checkbox"/> hepatitis             | <input type="checkbox"/> gout                 | <input type="checkbox"/> venereal disease   |
| <input type="checkbox"/> recurrent bronchitis | <input type="checkbox"/> cirrhosis             | <input type="checkbox"/> diabetes             | <input type="checkbox"/> cancer             |
| <input type="checkbox"/> recurrent pneumonia  | <input type="checkbox"/> bleeding disorder     | <input type="checkbox"/> thyroid problems     | <input type="checkbox"/> TMJ                |

## SURGICAL HISTORY (list any surgical procedures you have had and give the date)

\_\_\_\_\_  
\_\_\_\_\_

List cosmetic procedures you have had done: \_\_\_\_\_

\_\_\_\_\_

Were there any complications? \_\_\_\_\_

\_\_\_\_\_

Were you satisfied with those procedures? \_\_\_\_\_

\_\_\_\_\_

If not, why? \_\_\_\_\_

\_\_\_\_\_

## SYSTEM REVIEW (check symptoms that have been an ongoing problem for over the last 3 months)

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> chest pain                 | <input type="checkbox"/> excessive hunger      | <input type="checkbox"/> fever                    | <input type="checkbox"/> hives                 |
| <input type="checkbox"/> persistent cough           | <input type="checkbox"/> excessive thirst      | <input type="checkbox"/> fainting                 | <input type="checkbox"/> nosebleeds            |
| <input type="checkbox"/> shortness of breath        | <input type="checkbox"/> vomiting blood        | <input type="checkbox"/> constant headache        | <input type="checkbox"/> loss of hearing       |
| <input type="checkbox"/> ankle swelling             | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> insomnia                 | <input type="checkbox"/> ringing in ears       |
| <input type="checkbox"/> heartburn                  | <input type="checkbox"/> blood in urine        | <input type="checkbox"/> weight loss              | <input type="checkbox"/> sinus problems        |
| <input type="checkbox"/> indigestion                | <input type="checkbox"/> painful urination     | <input type="checkbox"/> weight gain              | <input type="checkbox"/> persistent hoarseness |
| <input type="checkbox"/> sour/bitter taste in mouth | <input type="checkbox"/> frequent urination    | <input type="checkbox"/> depression               | <input type="checkbox"/> double vision         |
| <input type="checkbox"/> stomach pain               | <input type="checkbox"/> muscle/join pain      | <input type="checkbox"/> heat or cold intolerance | <input type="checkbox"/> change in vision      |
| <input type="checkbox"/> constipation               | <input type="checkbox"/> easy bruising         | <input type="checkbox"/> extreme tiredness        | <input type="checkbox"/> vertigo               |
| <input type="checkbox"/> diarrhea                   | <input type="checkbox"/> change in moles       | <input type="checkbox"/> snoring                  | <input type="checkbox"/> abnormal bleeding     |
| <input type="checkbox"/> loss of appetite           | <input type="checkbox"/> sore that won't heal  | <input type="checkbox"/> hayfever                 |  |

Current Weight \_\_\_\_\_ Current Height \_\_\_\_\_

What Pharmacy do you use \_\_\_\_\_ Phone # \_\_\_\_\_

**MEDICATIONS** list medicines you are taking and the dose and frequency)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATION ALLERGIES** (list the medications you are allergic to and the type of reaction)

\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HISTORY** (check if your blood relatives had any of the following)

- asthma
- heart disease
- kidney disease
- cancer
- strokes
- bleeding disorder
- diabetes
- high blood pressure
- malignant hyperthermia

**HEALTH HABITS**

Have you ever been a smoker?  yes  no

If so, how many packs a day? \_\_\_\_\_

Have you stopped?  yes  no If yes, when did you stop? \_\_\_\_\_

Do you drink alcoholic beverages frequently?  yes  no

If so, what type and how many per day? \_\_\_\_\_

Do you use any illicit or recreational drugs?  yes  no

Are you under an unusual amount of stress?  yes  no

Do you exercise regularly (at least 3 time per week)?  yes  no

Do you take any herbs or other types of dietary supplements?  yes  no

**WOMEN ONLY**

Date of last menstrual period \_\_\_\_\_ Are they regular?  yes  no

Are you pregnant?  yes  no Number of children \_\_\_\_\_ Ages \_\_\_\_\_

I certify that the above provided health information is truthful and fully accurate.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Tuesday Bigelow, MD