HEALTH HISTORY

Patient Name ____ Birthdate_______________ Date _____________

Chief Complaint: ____

History of Present Illness:

Location _________________________________
(Where is the pain/problem?)

Quality ____
(Example: normal versus abnormal color, activity, etc.)

Severity ___________________________________
(How sever is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration _______________________________________
(How long have you had this pain/problem or When did it start?)

Timing ____________________________________
(Does the pain/problem occur at a specific time?)

Context ____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms __________________
____
(What other associated problems have you been having?)

Modifying factors _______________________________
____
(What makes the pain/problem worse or better?)

Past Medical History

Have you ever had the following: (Circle "yes" or "no", leave blank if uncertain)

Measles................	no	yes	Anemia....................	no	yes	Back trouble...............	no	yes	Hepatitis..................	no	yes
Mumps.................	no	yes	Bladder Infections.....	no	yes	High Blood Pressure...	no	yes	Ulcer........................	no	yes
Chickenpox...........	no	yes	Epilepsy....................	no	yes	Low Blood Pressure.....	no	yes	Kidney Disease.........	no	yes
Whooping Cough..	no	yes	Migraine headaches...	no	yes	Hemorrhoids................	no	yes	Thyroid Disease........	no	yes
Scarlet Fever.........	no	yes	Tuberculosis..............	no	yes	Date of last x-ray____________			Bleeding tendency....	no	yes
Diptheria..............	no	yes	Diabetes....................	no	yes	Asthma........................	no	yes	Any other disease.....	no	yes
Smallpox..............	no	yes	Cancer.......................	no	yes	Hives or Eczema..........	no	yes	(please list):		
Pneumonia...........	no	yes	Polio..........................	no	yes	AIDS or HIV+............	no	yes	________________________		
Rheumatic Fever...	no	yes	Glaucoma...................	no	yes	Infectious Mono...........	no	yes			
Heart Disease........	no	yes	Hernia........................	no	yes	Bronchitis....................	no	yes	________________________		
Arthritis................	no	yes	Blood or Plasma			Mitral Valve Prolapse..	no	yes			
Venereal Disease..	no	yes	Transfusions...........	no	yes	Stroke..........................	no	yes	________________________		

Previous Hospitalizations / Surgeries / Serious Illnesses | When | Hospital, City, State

____ ______________ ________________________

____ ______________ ________________________

____ ______________ ________________________

Medications (include nonprescription) ____

____

____

Patient Social History:

Marital status Single_____ Married ______ Partner _____ Separated _____ Divorced_____ Widowed ____

Use of alcohol: Never _____ Rarely _______ Moderate _____ Daily ______

Use of tobacco: Never _____ Previously, but quit ______ Current packs/day ________

Use of drugs: Never _____ Type / Frequency: ______________________________

Excessive exposure at home or at work to:

Fumes: _________ Dust: ________ Solvents: ________Airborne particles: ________ Noise: ________

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	________	________________________	________________________
Mother	________	________________________	________________________
Siblings	________	________________________	________________________
	________	________________________	________________________
	________	________________________	________________________
Spouse	________	________________________	________________________
Children	________	________________________	________________________
	________	________________________	________________________

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms
Good general health lately........... No Yes
Recent weight change.................. No Yes
Fever... No Yes
Fatigue... No Yes
Headaches .... No Yes

Eyes
Eye disease or injury .... No Yes
Wear glasses/ contact lenses .... No Yes
Blurred or double vision.............. No Yes

Ears/Nose/Mouth/Throat
Hearing loss or ringing.................No Yes
Earaches or drainage .... No Yes
Chronic sinus problems or rhinitis No Yes
Nose Bleeds .... No Yes
Mouth Sores .... No Yes
Bleeding gums .... No Yes
Bad breath or bad taste .... No Yes
Sore throat or voice change ....No Yes
Swollen glands in neck .... No Yes

Cardiovascular
Heart trouble .... No Yes
Chest pain or angina pectoris ...... No Yes
Palpitation .... No Yes
Shortness of breath w/walking .... No Yes
or lying flat .... No Yes
Swelling of feet, ankles, or hands No Yes

Respiratory
Chronic or frequent coughs .... No Yes
Spitting up blood .... No Yes
Shortness of breath .... No Yes
Wheezing .... No Yes

Gastrointestinal
Loss of appetite .... No Yes
Change in bowel movements ..... No Yes
Nausea or vomiting .... No Yes
Frequent diarrhea .... No Yes
Painful bowel movements
or constipation .... No Yes
Rectal bleeding or blood in stool No Yes
Abdominal pain .... No Yes

Genitourinary
Frequent urination...................... No Yes
Burning or painful urination....... No Yes
Blood in urine............................ No Yes
Change in force of stream No Yes
when urinating........................... No Yes
Incontinence or dribbling........... No Yes
Kidney stones .... No Yes
Sexual difficulty .... No Yes
Please answer as applicable:
Testicular pain………………… No Yes
Irregular periods .... No Yes
Vaginal discharge..................... No Yes
No. of pregnancies.................. _______
No. of miscarriages .... _______
Date of last pap smear ………. _______
Last menstrual period………… _______

Musculoskeletal
Joint pain ....No Yes
Joint stiffness or swelling ....No Yes
Weakness of muscles or joints.... No Yes
Muscle pain or cramps ....No Yes
Back pain ....No Yes
Cold extremities .... No Yes
Difficulty in walking ....No Yes

Integumentary (skin, breast)
Rash or itching ....No Yes
Change in skin color ....No Yes
Change in hair or nails .... No Yes
Varicose veins .... No Yes
Breast pain .... No Yes
Breast lump .... No Yes
Breast discharge .... No Yes

Neurological
Frequent or recurring headaches No Yes
Light headed or dizzy .... No Yes
Convulsions or seizures .... No Yes
Numbness or tingling .... No Yes
Tremors .... No Yes
Paralysis .... No Yes
Head injury .... No Yes

Psychiatric
Memory loss or confusion...... No Yes
Nervousness........................... No Yes
Depression.............................. No Yes
Insomnia .... No Yes

Endocrine
Glandular or hormone
problem...................................No Yes
Excessive thirst or urination.... No Yes
Heat or cold intolerance..........No Yes
Skin becoming dryer ....No Yes
Change in hat or glove size......No Yes

Hematologic/Lymphatic
Slow to heal after cuts.............No Yes
Bleeding or bruising tendency No Yes
Anemia...................................No Yes
Phlebitis .... No Yes
Past transfusions .... No Yes
Enlarged glands .... No Yes

Allergic/Immunologic
History of skin reaction or other adverse reaction to:
Penicillin or other antibiotic No Yes
Morphine, Demerol,
or other narcotics .... No Yes
Novocain or other anesthetic No Yes
Aspirin or other pain drugs No Yes
Tetanus antitoxin
or other serums .... No Yes
Iodine, Merthiolate or
other antiseptic .... No Yes
Other drugs/medications: ____________
____
Known food allergies:_______________
____
Environmental allergies: _____________
____
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

______________________________ ______________________________
Signature of Patient, Parent or Guardian Date