## **HEALTH HISTORY**

## Confidential

Patient Name	ameToday's Date		Date					
Age Birthdate		Date of last physical examination						
What is your reason for	visit?							
SYMPTOMS Check	د (🗸) symp	ptoms you currently have or have	had in the past year.					
GENERAL		GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN only				
☐ Chills		☐ Appetite poor	☐ Bleeding gums	☐ Breast lump				
☐ Depression		☐ Bloating	☐ Blurred vision	☐ Erection difficulties				
☐ Dizziness		☐ Bowel changes	☐ Crossed eyes	☐ Lump in testicles				
☐ Fainting		☐ Constipation	☐ Difficulty swallowing	Penis discharge				
☐ Fever		☐ Diarrhea	☐ Double vision	☐ Sore on penis				
☐ Forgetfulness		☐ Excessive hunger	☐ Earache	☐ Other				
☐ Headache		☐ Excessive thirst	☐ Ear discharge					
☐ Loss of sleep		☐ Gas	☐ Hay fever	WOMEN only				
Loss of weight		☐ Hemorrhoids	☐ Hoarseness	☐ Abnormal Pap Smear				
☐ Nervousness		☐ Indigestion *	☐ Loss of hearing	Bleeding between periods				
☐ Numbness		☐ Nausea	☐ Nosebleeds	☐ Breast lump				
☐ Sweats		☐ Rectal bleeding	☐ Persistent cough	Extreme menstrual pain				
		☐ Stomach pain	☐ Ringing in ears	☐ Hot flashes				
MUSCLE/JOINT/E	<b>30NE</b>	☐ Vomiting	☐ Sinus problems	☐ Nipple discharge				
Pain, weakness, numb	ness in:	☐ Vomiting blood	☐ Vision – Flashes	☐ Painful intercourse				
☐ Arms ☐ Hip:		-	☐ Vision – Halos	☐ Vaginal discharge				
☐ Back ☐ Leg		CARDIOVASCULAR		☐ Other				
☐ Feet ☐ Ned	ck	☐ Chest pain	SKIN	Date of last				
☐ Hands ☐ Sho	oulders	☐ High blood pressure	☐ Bruise easily	menstrual period				
		☐ Irregular heart beat	☐ Hives	Date of last				
GENITO-URINA	RY	Low blood pressure	☐ Itching	Pap Smear				
☐ Blood in urine		Poor circulation	☐ Change in moles	Have you had				
☐ Frequent urination		☐ Rapid heart beat	☐ Rash	a mammogram?				
Lack of bladder con	itrol	☐ Swelling of ankles	☐ Scars	Are you pregnant?				
☐ Painful urination		☐ Varicose veins	☐ Sore that won't heal	Number of children				
CONDITIONS Che	ck (🗸) con	nditions you have or have had in t	the past					
□ AIDS		☐ Chemical Dependency	☐ High Cholesterol	☐ Prostate Problem				
Alcoholism		☐ Chicken Pox	☐ HIV Positive	☐ Psychiatric Care				
☐ Anemia		☐ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever				
☐ Anorexia		☐ Emphysema	☐ Liver Disease	☐ Scarlet Fever				
Appendicitis		☐ Epilepsy	☐ Measles	☐ Stroke				
☐ Arthritis		☐ Glaucoma	☐ Migraine Headaches	☐ Suicide Attempt				
☐ Asthma		Goiter	☐ Miscarriage	☐ Thyroid Problems				
☐ Bleeding Disorders		☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis				
☐ Breast Lump		Gout	☐ Multiple Sclerosis	☐ Tuberculosis				
☐ Bronchitis		☐ Heart Disease	☐ Mumps	☐ Typhoid Fever				
☐ Bulimia		☐ Hepatitis	☐ Pacemaker	Ulcers				
☐ Cancer		☐ Hernia	☐ Pneumonia	☐ Vaginal Infections				
☐ Cataracts		☐ Herpes	☐ Polio	☐ Venereal Disease				
MEDICATIONS Lis	t medicati	ions you are currently taking.	om tomo manda de Ecciestro.	medications or substances				
				erarra, daren artera batuarra per				
Pharmacy Name		Phone						

All information is strictly confidential

Relation	Age	State of Health	Age at Death	Cause	of Death	Check		od rela ease	atives h	ad any of the following: Relationship to you
Father							Arthritis, Gou	t		·
Mother							Asthma, Hay	Fever		
rothers	s Cancer									
							Chemical Dependency			
		<b></b>		• •			Diabetes			
							Heart Diseas	e, Strok	es	
Sisters							High Blood P	ressure	) .	- 0.000
							Kidney Disea	se.		
					-		Tuberculosis			
							Other			
HOSPIT/	ALIZA	TIONS			J. Dr. Wilde Co. Day Cangle			PRE	GNAN	Y HISTORY
/ear		Hospital		Reaso	on for Hospi	talization a	ind Outcome	Year of Birth	Sex of Birth	Complications if any
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						100 100				
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				<del> </del>						
		manufa 5 1 1		·			subst	ances y	BITS Check (🗸) which ou use and describe how	
	•						much	you use		
								Caffeir		
Have you ever had a blood transfusion?  If yes, please give approximate dates.			☐ Yes	□ No To			Tobacc	20		
			S		*** <b>*</b> ********************************			Street	Drugs	
SERIOUS	ILLNI	ESS/INJUF	NES		DATE	QUI	COME		Other	
				1						
										gr.
								occ	UPATIO	NAL CONCERNS
- 4.1									k (✔) if y llowing:	our work exposes you to
								uio io	Stress	
									<del>                                     </del>	leur Cubatanasa
					· · · · · · · · · · · · · · · · · · ·					lous Substances
									Heavy	Litting
									Other	
								Your	occupati	on:
		ledge, the ab	ove information	is complete	and correct. I u	nderstand that	it is my responsibilit	y to inforr	n my docto	r if I, or my minor child, ever have a
ange in hea	utl+-									
	Sig	nature of Pati	ent, Parent, Gu	iardian or Pe	rsonal Represe	ntative				Date
	D.	- 4	D-6		or Personal Rep	monnt-thir-		-	Б.	elationship to Patient