

Health History Form

Patient Name: _____ Date: _____ / _____ / _____
Month Day Year

DOB: _____ / _____ / _____ Age: _____ Last Menstrual Period: _____ / _____ / _____
Month Day Year Month Day Year

Referring Physician: _____

Main reason for today's visit:
(200 characters maximum)

REVIEW OF SYMPTOMS: Have you had or still have any of the following? (Check all that apply.)

Constitutional

- Recent fevers/sweats
- Unexplained weight loss/gain
- Unexplained fatigue/weakness
- None apply

Eyes

- Change in vision
- Glaucoma
- Cataract
- Blurry/double vision
- None apply

Ears/Nose/Throat/Mouth

- Difficulty hearing
- Hay fever/allergies/congestion
- Trouble swallowing
- Voice changes
- None apply

Breast

- Breast lumps
- Axillary node lumps
- Nipple discharge
- Skin dimpling
- None apply

Liver Disease

- Jaundice
- Hepatitis

Liver Disease (cont.)

- Cirrhosis
- None apply

Respiratory

- Cough/wheeze
- Coughing up blood
- Emphysema
- Asthma
- Bronchitis
- None apply

Cardiovascular

- Chest pains/discomfort
- Short of breath with exertion
- Palpitation
- Angina
- High blood pressure
- Aneurysm
- Mitral valve prolapse
- Defibrillator/Pacemaker
- None apply

Musculoskeletal

- Muscle/joint pain
- Recent back pain
- Arthritis
- Osteoporosis
- None apply

Gastrointestinal

- Heartburn/reflux
- Blood in stool
- Nausea/vomiting
- Pain in abdomen
- Clay colored stool
- Dark urine
- Diarrhea
- Constipation
- None apply

Genitourinary

- Painful/bloody urination
- Nighttime urination
- Discharge: penis or vagina
- Unusual vaginal bleeding
- Concern with sex functions
- None apply

Endocrine

- Cold/heat intolerance
- Increase thirst/appetite
- Thyroid disease
- Parathyroid
- Diabetes
- Pancreas
- Adrenal
- None apply

Psychiatric

- Anxiety/stress
- Sleep problems
- Depression
- None apply

Neurological

- Headaches
- Memory loss
- Fainting
- Seizures
- Weakness
- None apply

Blood/Lymphatic

- Unexplained lumps
- Easy bruising/bleeding
- Blood clot
- None apply

Skin

- Rash
- New or change in mole
- Jaundice
- Cancer
- None apply

*For additional symptoms,
please write on last page.*

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Patient Name: _____ DOB: ___/___/___ Date: ___/___/___

CURRENT MEDICAL PROBLEMS: List ALL current medical problems (*CHF, high cholesterol, etc.*)

Medical Problem

1)
2)
3)
4)
5)

Medical Problem

6)
7)
8)
9)
10)

MEDICATIONS: List ALL current medications (*prescription, vitamins, herbal, and over the counter*)

Name of medicine / Dose/mg / Frequency/time of day

1)
2)
3)
4)
5)

Name of medicine / Dose/mg / Frequency/time of day

6)
7)
8)
9)
10)

OPERATIONS: List ALL operations and dates

Operation / Date

1)
2)
3)
4)
5)

Operation / Date

6)
7)
8)
9)
10)

ALLERGIES: List ALL allergies with reactions including medications, food, and environmental

Allergy / Reaction

1)
2)
3)
4)
5)

Allergy / Reaction

6)
7)
8)
9)
10)

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FAMILY HISTORY: Has anyone in your family had the following? List relationship (*ex. parent, sibling, etc.*)

- Heart disease/heart attack _____
- High blood pressure _____
- Diabetes _____
- Cancer _____
- Stroke/vascular disease _____
- Other _____

SOCIAL HISTORY:

Tobacco Use

Cigarettes Never Quit Date: _____ Current Smoker Packs/Day: _____ # of Years: _____

Alcohol Use

Do you drink alcohol? Yes No # of Drinks/Week: _____

Drug Use

Do you use or have you used any recreational drugs? Yes No

If Yes, list drug(s) and last date used: _____

Have you ever used needles to inject drugs? Yes No

SOCIOECONOMICS:

Occupation: _____ Employer: _____

Years of Education/Highest Degree: _____

Marital Status: Single Married Widowed Divorced

Spouse's/Partner's Name: _____

of Children: _____ Ages: _____

Who lives at home with you?: _____



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ADDITIONAL NOTES: Write any notable information not included in the form.