

## 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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Patient Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

**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.