Health History

«PName» «PNumber»

To help us meet your healthcare needs, please fill out all pages of this form completely in ink. This is a confidential record of your medical history and will be kept in this office.

Today's Date:_____
Place of Birth:_____
Highest Level in School:_____
Occupation:_____
Previous Occupations:_____
Marital Status:_____
Hobbies:_____
Exercise/recreation:_____
Habits:
Smoking (type & amount per day):_____
If former smoker, date quit:_____
Alcohol (type & amount per week):_____
Caffeine (type & amount per day):_____
Usual Weight:_____
Date of Last Dental Exam:_____
Please list all allergies (foods, drugs, environment):

When was your last physical exam?:_____
Name of Doctor:_____Ph:_____
Please list all serious illnesses, operations & other hospitalizations you have experienced & indicate the year these occurred: ☐None

Please list all medications you are currently taking (include non-prescription drugs): ☐None

Describe all serious accidents, severe injuries, head injury, fracture or broken bones (include date occurred): ☐None

Surgical History

Please list any past or scheduled surgery:

Past Medical History

Have you ever had the following?: (Circle "No" or "Yes", leave blank if uncertain)

Measles	No	Yes	Migraine Headaches	No	Yes	Infectious Mono	No	Yes
Mumps	No	Yes	Tuberculosis	No	Yes	Bronchitis	No	Yes
Chickenpox	No	Yes	Diabetes	No	Yes	Mitral Valve Prolapse	No	Yes
Whooping Cough	No	Yes	Cancer	No	Yes	Stroke	No	Yes
Scarlet Fever	No	Yes	Polio	No	Yes	Hepatitis	No	Yes
Diphtheria	No	Yes	Glaucoma	No	Yes	Ulcer	No	Yes
Smallpox	No	Yes	Hernia	No	Yes	Kidney Disease	No	Yes
Pneumonia	No	Yes	Blood or Plasma Transfusions	No	Yes	Thyroid Disease	No	Yes
Rheumatic Fever	No	Yes	Back Trouble	No	Yes	Bleeding Tendency	No	Yes
Heart Disease	No	Yes	High or low Blood Pressure	No	Yes	Any other disease	No	Yes
Arthritis	No	Yes	Hemorrhoids	No	Yes	(please list)		
Venereal Disease	No	Yes	Asthma	No	Yes			
Anemia	No	Yes	Hives or Eczema	No	Yes			
Bladder Infection	No	Yes	AIDS or HIV+	No	Yes			
Epilepsy	No	Yes	Date of last chest x-ray:					

«PName» «PNumber»

Family History

Has any blood relative had any of the following?: (Circle "No" or "Yes", leave blank if uncertain)

			Relationship				Relationship
Cancer	No	Yes		Drug or Alcohol Problem	No	Yes	
Tuberculosis	No	Yes		Mental Illness	No	Yes	
Diabetes	No	Yes		Leukemia	No	Yes	
Heart Disease	No	Yes		Migraine Headaches	No	Yes	
High Blood Pressure	No	Yes		Obesity	No	Yes	
Stroke	No	Yes		Thyroid Disease	No	Yes	
Epilepsy	No	Yes		Ulcer	No	Yes	
Allergies	No	Yes		Depression	No	Yes	
Anemia	No	Yes		High Cholesterol	No	Yes	
Bleeding Tendency	No	Yes		Kidney Disease	No	Yes	
Asthma	No	Yes		Glaucoma	No	Yes	
Chronic Lung Disease	No	Yes		Gout	No	Yes	

	Present age, or age of death	If living, health (good, fair, poor). If deceased, cause of death
Father:		
Mother:		
Siblings:		
Spouse:		
Children:		

Do you now or have you had within the past year: (Circle "No" or "Yes", leave blank if uncertain)

Weakness or paralysis	No	Yes	Loss of smell	No	Yes	Rectal bleeding	No	Yes
Tire easily or weakness	No	Yes	Persistent hoarseness	No	Yes	Black tarry stools	No	Yes
Recent weight changes	No	Yes	Sore throat	No	Yes	Dark Urine	No	Yes
Change in appetite	No	Yes	Sore tongue or gums	No	Yes	Yellow jaundice	No	Yes
Sensitivity to cold or heat	No	Yes	Lump or discharge from breast	No	Yes	Frequent urination (day)	No	Yes
Persistent fever	No	Yes	Chronic or frequent cough	No	Yes	Frequent urination (night)	No	Yes
Night sweats or hot flashes	No	Yes	Shortness of breath	No	Yes	Increase in thirst	No	Yes
Skin rash	No	Yes	Bloody sputum	No	Yes	Painful urination	No	Yes
Skin trouble or changes	No	Yes	Wheezing	No	Yes	Leakage of urine	No	Yes
Change in nails or hair	No	Yes	Chest pain or discomfort	No	Yes	Difficulty in starting urine	No	Yes
Headaches	No	Yes	Purple fingers or lips	No	Yes	Blood in urine	No	Yes
Easy bleeding or bruising	No	Yes	Swelling of hands, feet or ankles	No	Yes	Lack of sex drive	No	Yes
Double vision	No	Yes	Difficulty in breathing	No	Yes	Hemorrhoids	No	Yes
Blurred vision	No	Yes	Palpitations or heart fluttering	No	Yes	Backaches	No	Yes
Eye pain	No	Yes	Leg cramps walking or at night	No	Yes	Joint Pain or Stiffness	No	Yes
Infected eyes	No	Yes	Enlarged veins	No	Yes	Swollen Joints	No	Yes
Do you wear glasses or contacts?	No	Yes	Difficulty swallowing	No	Yes	Muscle cramps/spasms	No	Yes
When was your last eye exam?			Heartburn	No	Yes	Sleeplessness	No	Yes
Ringing in the ears	No	Yes	Frequent belching	No	Yes	Seizures	No	Yes
Discharge from ears	No	Yes	Abdominal cramping	No	Yes	Depression	No	Yes
Ear pain	No	Yes	Nausea	No	Yes	Memory Loss	No	Yes
Decrease in hearing	No	Yes	Vomiting	No	Yes	Poor Coordination	No	Yes
Frequent nosebleeds	No	Yes	Vomited or coughed up blood	No	Yes	Dizziness or fainting	No	Yes
Frequent colds	No	Yes	Chronic diarrhea	No	Yes	A living will or		
Sinus trouble	No	Yes	Chronic constipation	No	Yes	advanced directive	No	Yes

Signature of patient or parent, if a minor

Date