HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: _____

Patient Name _____ Birth Date _____ Patient#_____

Chief Complaint: _____

History of present illness:

Location:_____
(Where is the pain/problem?)

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

Severity_____
(How severe 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? 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 problem have you been having?)

Modifying factors_____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", 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
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 chest x-ray _____			Bleeding Tendency	no	yes
Diphtheria	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	Transactions	no	yes	Stroke	no	yes	_____		

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

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medications: (Include nonprescription) _____
_____
_____

Patient social history:

Marital status Single: _____ Married: _____ 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 Air-borne
at home or work to: Fumes:____ Dust: _____ Solvents: _____ Particles: _____ Noise:_____

Family medical history:

	Age	Disease	If Deceased, Caused 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 problem
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
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
Short ness 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 strain
when urinating..... No Yes
Incontinence or dribbling..... No Yes
Kidney stones..... No Yes
Sexual difficulty..... No Yes
Male – testicle pain..... No Yes
Female – pain with periods..... No Yes
Female – irregular periods..... No Yes
Female – vaginal discharge..... No Yes
Female - # of pregnancies..... _____
Female - # of miscarriages..... _____
Female – date of
last pap smear..... _____

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 sensations..... No Yes
Tremors..... No Yes
Paralysis..... No Yes
Head injury No Yes

Psychiatric
Memory loss or confusion..... No Yes
Nervoursness..... 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 transfusion..... No Yes
Enlarged glands..... No Yes

Allergic/Immunologic
History of sking reaction or ther adverse reaction to:
Penicillin or other antibiotics..... No Yes
Morphine, Demerol,
or other narcotics..... No Yes
Novocain or other anesthetics..... No Yes
Aspirin or other pain remedies..... No Yes
Tetanus antitoxin
or other serums..... No Yes
Iodine, Merthiolate or..... No Yes
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

Doctor's Review

_____ _____

Signature of Doctor Date