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HEALTH HISTORY FORM

Name: _____ Social Security No: _____
Date: _____ Birthdate: _____

Reason for Visit: _____

Symptoms: Please check the symptoms you currently have or had in the past year:

General: Fever _____ Chills ____ Weight Gain ____ Weight Loss ____ Fatigue ____
Loss of Appetite ____
Eyes: Glaucoma ____ Retinopathy ____
ENT: Sinus Drainage ____ Hoarseness ____ Sore Throat ____
Heart: High Blood Pressure ____ Heart Attack ____ Chest Pain ____ High Cholesterol ____
History of Heart Valve Infection ____ Artificial Valve ____
Pulmonary: Shortness of Breath ____ Cough ____ Asthma ____ Emphysema/Bronchitis ____
GI: Abdominal Pain ____ Nausea ____ Vomiting ____ Heart Burn ____
Difficulty Swallowing ____ Change in Bowel Habits ____ Constipation ____
Diarrhea ____ Rectal Pain ____ Rectal Bleeding ____
GU: Male Blood in Urine ____ Urinary Frequency ____ Nocturnal Urination ____
Female Blood in Urine ____ Burning ____ Incontinence ____ Mammogram ____
Pelvic Exam and PAP Smear ____ Hormone Replacement Therapy ____
Joints/Muscle: Back Pain ____ Joint Pain ____ Joint Swelling ____
Skin: Rashes ____ Cancer ____
Neurologic: Stroke ____ Seizures ____ Headache ____
Psychiatric: Depression ____ Anxiety ____
Endocrine: Diabetes ____ Thyroid ____
Hematologic: Anemia ____ Swollen Glands ____ Easy Bruising ____

Medical History: Please list significant current and past medical problems:

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Surgical History: Please list prior surgeries and date of operation:

1) _____ 2) _____ 3) _____

Medications: Please list medications you are currently taking, dose and frequency:

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

HEALTH HISTORY FORM (Cont'd.)

Name: _____ Social Security No: _____
Date: _____ Birthdate: _____

Allergies: Please list medications you are allergic to and type of reaction:

1) _____ 2) _____ 3) _____

Health Habits: Please check the substances you use and describe how much you use:

Tobacco _____ Alcohol _____ Caffeine _____ Drugs _____

Social History: Married ____ Divorced ____ Single ____ Widow ____ Partner ____

Children: _____ Occupation: _____

Family History: Please fill in your family's health information:

	Age	Health Conditions	Age at Death	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
	_____	_____	_____	_____

Any significant gastrointestinal illnesses in family members? Please list:

1) _____

2) _____

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor, or any members of his staff, responsible for any errors or omissions that I may have in the completion of this form.

_____ _____
Signature Date

_____ _____
Reviewed By Date