

HEALTH HISTORY

(Confidential)

Name: _____ Today's Date: _____

Age: _____ Birthdate: ____/____/____ Date of last Physical Examination: _____

What is the reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year

<p>GENERAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite Poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel Changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach Pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood	<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Cross Eyes <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Double Vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Hay Fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Vision – Flashes <input type="checkbox"/> Vision – Halos	<p>MEN only</p> <input type="checkbox"/> Breast Lump <input type="checkbox"/> Erection Difficulties <input type="checkbox"/> Lump in Testicles <input type="checkbox"/> Penis Discharge <input type="checkbox"/> Sore Penis <input type="checkbox"/> Other	
<p>MUSCLE/JOINT/BONE Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Swelling of Ankles <input type="checkbox"/> Varicose Veins	<p>SKIN</p> <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in Moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that Won't Heal	<p>WOMEN only</p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast Lump <input type="checkbox"/> Extreme Menstrual Pain <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Other	
				<p>Date of Last Menstrual Period: _____ Date of Last Pap Smear: _____ Have you had a Mammogram? _____ Are you Pregnant? _____ Number of Children? _____</p>

CONDITIONS Check (✓) conditions you have or have had in the past

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease
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<p>MEDICATIONS List medications you are currently taking:</p> Pharmacy Name: _____ Phone Number: _____	<p>ALLERGIC REACTIONS to medications or substances:</p>
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