

# Patient Health History

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

**Chief Complaint:** What is the reason for your visit today? (Please describe problem in detail including history of present illness):

**Past Medical History:** Please check all that apply to you:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Raynaud's       |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> HIV                  | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Seizures        |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> Mitral Valve         | <input type="checkbox"/> Thyroid         |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> Ulcers (GI)     |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Neuropathy           | <input type="checkbox"/> Lupus           |
| <input type="checkbox"/> Diabetes (Type I or II)  | <input type="checkbox"/> Poor circulation     | <input type="checkbox"/> Other           |
| <input type="checkbox"/> Chronic Fatigue syndrome | <input type="checkbox"/> Psychiatric disease  |  |
| <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Fibromyalgia         |  |
| <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Rheumatoid Arthritis |  |

**Previous Surgeries:** Please list past surgeries with approximate date:

**Medications:** Please list any medications you are taking with dose and frequency:

*Drug Dose/Frequency*

**Allergies (Drug, Food, Latex, etc.):** Please list any allergies that you have and type of reaction

**Social History:**

Do you drink alcohol? Yes No If yes, how much/week?

Do you smoke? Yes No If yes, how many cigarettes/day?

Do you consume caffeine? Yes No If yes, how many cups/week?

Do you use recreation drugs? Yes No If yes, what type and frequency?

Are you on a special diet? Yes No If yes, please describe?

**Family History:** Do you know of any blood relative who has or had:

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Aneurysm    | <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Thyroid            |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> None               |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Lung Disease        | <b>Comments:</b>                            |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Migraine            |   |

**General Health**

- Good general health
- Recent weight change
- Loss of appetite
- Fatigue
- Fever/chills

**Allergy**

- Drug allergies
- Food allergies
- Hay fever
- Other:
- None

**Ears, Nose, Mouth, Throat**

- Difficulty swallowing
- Earaches
- Loss of hearing/deafness
- Loss of smell
- Loss of taste
- Ringing in ears
- Sinus infection
- Sores in mouth
- None
- Other:

**Eyes**

- Blind spots
- Blurred vision
- Double vision
- Loss of vision
- Glaucoma
- Pain
- Other:
- None

**Gastrointestinal**

- Blood in stool
- Nausea
- Painful bowel movements
- Persistent diarrhea
- Stomach or abdominal pain
- Ulcer
- Vomiting
- Other:
- None

**Neurological**

- Balance trouble
- Mini stroke
- Stroke
- Tremors
- Weakness
- Both
- Numbness or tingling
- Paralysis
- Neuropathy
- Black outs/loss of consciousness
- Memory loss
- Mental Confusion
- Migraines

**Genitourinary**

- Blood in urine
- Female: irregular periods
- Female: #pregnancies\_\_\_\_\_
- #miscarriages\_\_\_\_\_
- Kidney stones
- Painful or burning urination
- Sexual difficulty
- Sexually transmitted disease
- Urgency with urination
- Other:
- None

**Heart and Lungs**

- Pain in chest
- High blood pressure
- High cholesterol
- Irregular heart beat
- Other:
- None

**Muscles/Joints/Bones**

- Back pain
- Difficulty walking
- Joint pain
- Joint stiffness or swelling
- Muscle pain or tenderness
- Neck pain
- None

**Psychiatric**

- Depression
- Anxiety
- Eating disorder
- Other: \_\_\_\_\_
- None

**Pulmonary**

- Asthma
- Blood in cough
- Cancer
- Chronic or frequent cough
- Emphysema
- Pneumonia
- Shortness of breath
- Other: \_\_\_\_\_
- None

**Skin**

- Rash or itching
- Sun sensitivity
- Color changes
- Other: \_\_\_\_\_
- None

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**Patient Name**