

Health History

Name: _____ Date: _____

Primary Doctor: _____

Past Medical History: Please check all that apply to you

- | | | |
|--------------------------------------------|----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Ulcer/GERD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Blackouts |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric disease | _____ |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Thyroid | _____ |

Allergies to medications: _____

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

Serious Injury: _____

Social History:

Occupation: _____

Marital Status: _____ Children: _____

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/day? _____

Do you use recreational 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"/> Headaches | <input type="checkbox"/> Psychiatric disease |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Brain tumor | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cancer, Type: _____ | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> None |
| <input type="checkbox"/> Dementia/Alzheimer's | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraine | _____ |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Multiple Sclerosis | _____ |

Comments: _____

Health History

REVIEW OF SYSTEMS

As you review the following list, please check any problems or conditions that you are experiencing or have experienced. If you do not have any problems listed in section please check none.

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
- Painful Chewing
- Ringing in Ears
- Sinus Infection
- Sores in Mouth
- None
- Other: _____

Eyes

- Blind spots
- Blurred Vision
- Double Vision
- Loss of Vision
- Glaucoma
- Injury
- Pain
- None
- Other: _____

Gastrointestinal

- Blood in Stool
- Increasing Constipation
- Nausea
- Painful Bowel Movements
- Persistent Diarrhea
- Stomach or Abdominal Pain
- Ulcer
- Vomiting
- None
- Other: _____

Signature: _____

Genitourinary

- Blood in Urine
- Female: Irregular Periods
- Female: #pregnancies__
- #miscarriages__
- Female: Vaginal Discharge
- Kidney Stones
- Male: Prostate Disease
- Male: Testicular Pain
- Painful or Burning Urination
- Sexually Difficulty
- Sexually Transmitted Disease
- Urgency with Urination
- Urine Retention/Incontinence
- 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

Neurological

- Balance Trouble
- Black Outs
- Difficulty Speaking
- Difficulty Walking
- Facial Drooping
- Headaches
- Injury to the Brain or Spine
- Light-headed or Dizziness
- Memory Loss
- Mental Confusion
- Migraines
- Mini Stroke

- Neuropathy
- Numbness or Tingling
- Paralysis
- Stroke
- Tremors
- Weakness
- Other: _____
- None

Are you?

- Right Handed
- Left Handed
- Both

Psychiatric

- Depression
- Anxiety
- Eating Disorder
- Other: _____
- None

Pulmonary

- Asthma
- Blood in Cough
- Cancer
- Chronic/Frequent Cough
- Emphysema
- Pneumonia
- Shortness of Breath
- Other: _____
- None

Skin

- Rash or Itching
- Sun Sensitivity
- Hair Loss
- Color Changes
- Other: _____
- None

Sleep

- Snoring
- Sleepwalking
- Nightmares
- Do you sleep well ? _____
- Do you feel rested when you wake? _____
- Do you fall asleep during the day? _____

Date: _____