HEALTH HISTORY

Patient Name_____ Date of Birth_____/_____/_____ Patient #_____

To help us meet all your healthcare needs, please fill out both sides of this form completely. This is a confidential record of your medical history and will be kept in this office.

Today's date_____When was your last physical exam? _____ Name of Doctor_____

Chief Complaints- Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:_____
_____
_____

Medical History- Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred:_____
_____
_____

Have you ever had the following (circle all that apply):

AIDS or HIV
Anxiety
Arthritis
Asthma
Autoimmune disorder
Bladder infections
Bleeding tendencies
Breast problems
Bronchitis
Cancer
Chicken pox
D(Rh) Sensitized
Depression/Postpartum depression
Diabetes
Diphtheria
Epilepsy
Glaucoma
Heart Disease
Hepatitis
Hepatitis/Liver Disease
Hernia
History of abnormal Pap
History of blood transfusions
Hives or Eczema
Hyperlipidemia/High Cholesterol
Hypertension/High Blood Pressure
Hyperthyroidism
Hypothyroidism
Infections mono
Infertility
Kidney disease
Kidney disease/UTI
Measles
Migraines
Mitral valve prolapse
Mumps
Neurologic/Epilepsy
Pneumonia
Polio
Psychiatric
Pulmonary condition
Rheumatic fever
Scarlet fever
Seasonal allergies
Smallpox
Stroke
Thyroid dysfunction
Tuberculosis
Ulcer
Uterine anomaly/DES
Varicosities/Phlebitis
Venereal disease
Whooping cough
Is blood transfusion OK? Y/N
Other_____
Other_____

Surgical History- Have you ever had surgery for the following (circle all that apply):

Abdominal surgery
Cardiac surgery
Cholecystectomy
Hernia repair
Tonsillectomy
Infertility treatment
Tubal ligation
C-Section
Hysterectomy
Mastectomy
No surgeries
Other_____
Other_____
Other_____
Other_____

Family History-

Please check the box if family members had the following conditions:	Alive (Y/N)	If deceased, age at death	Asthma	Breast Cancer	Uterine Cancer	Ovarian Cancer	Colon Cancer	Prostate Cancer	Depression	Diabetes, Type II	Epilepsy	Heart Disease	High Cholesterol	Hypertension	Mental Illness	Migraine headaches	Stroke	Thyroid disease	Other (specify)
Mother																			
Father																			
Sister																			
Brother																			
Maternal Grandmother																			
Maternal Grandfather																			
Paternal Grandmother																			
Paternal Grandfather																			

Social History-

Place of birth _____
Highest level in school_____
Occupation_____
Previous occupations_____
Marital status_____
Hobbies_____

Exercise/recreation_____
Tobacco (type & amount per day)_____
Alcohol (type & amount per week)_____
Caffeine (type & amount per day)_____
Street drugs (type & amount per day)_____

Obstetrical History-

Date of last period_____
Date of last pelvic exam_____
Date of last mammogram_____
Type of birth control used?_____

Number of pregnancies_____
Number of full term births_____
Number of preterm births_____

For each pregnancy, please provide the following information:

Date of Delivery (MM/DD/YYYY)	Weeks of Gestation	Length of Labor	Birth Weight (Lbs, Oz)	Gender	Place of Delivery	Preterm labor? (Y/N)	Complications? Specify.

Allergies- Please list all allergies (foods, drugs, environment):_____
_____
_____

Do you have now or have you had within in the past year (circle all that apply):

Chills
Fatigue
Persistent fever
Insomnia
Change in appetite
Night sweats or hot flashes
Recent weight changes
Tire easily or weakness
Blurred vision
Double vision
Eye pain
Headaches
Infected eyes
Vision loss
Wear glasses or contacts
Decrease in hearing
Discharge from ears
Ear pain
Hearing loss
Ringing in the ears
Frequent colds
Frequent nosebleeds
Loss of smell
Sinus trouble
Persistent hoarseness
Sore throat
Sore tongue or gums

Chest pain
Enlarged veins
Legs cramps at rest
Leg cramps on walking
Palpitations of the heart
Purple fingers or lips
Swelling of hands, feet, or ankles
Bloody sputum
Chronic or frequent cough
Difficulty in breathing
Wheezing
Abdominal cramping
Black tarry stools
Chronic constipation
Chronic diarrhea
Frequent belching
Heartburn
Hemorrhoids
Incontinence
Jaundice
Nausea
Rectal bleeding
Swallowing with difficulty
Vomiting
Vomiting blood
Blood in urine
Dark urine

Difficulty in starting urine
Frequent urination (day)
Frequent urination (night)
Increase in thirst
Painful urination
Abnormal vaginal bleeding
Breast mass
Breast tenderness
Genital sores
Lump or discharge from breast
Pain with intercourse
Vaginal discharge
Vaginal itching
Lack of sex drive
Backaches
Bruising
Joint swelling
Joint pain or stiffness
Muscle cramps or spasms
Changes in hair
Changes in nails
Skin rash
Skin trouble or changes
Dizziness or fainting spells
Memory loss
Poor Coordination
Seizures

Depression
Insomnia
Sensitivity to cold or heat

Additional comments:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list all medicines you are currently taking (include non-prescription drugs):

_____
_____
_____

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 health care services I may need.

X_____ _____

Signature of patient Date