HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date:_____

Patient Name _____ Birthdate _____

Chief Complaint: _____

History of present illness:

Location _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe)

Duration _____
(How long have you had this pain problem? Or, When did it start?

Timing _____
(Does the pain/problem occur at a specific time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms _____
_____
(What other associated pain/problems have you been having?)

Modifying factors _____
_____
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles . . . . . no yes	Anemia. . . . . no yes	Back trouble. . . . . no yes	Hepatitis. . . . . no yes
Mumps. . . . . no yes	Bladder infections. . . . no yes	High Blood Pressure. . . no yes	Ulcer. . . . . no yes
Chickenpox. . . . . no yes	Epilepsy. . . . . no yes	Low Blood Pressure. . .. no yes	Kidney Disease. . . . . no yes
Whooping Cough. . . . . no yes	Migraine Headaches. . . no yes	Hemorrhoids. . . . . no yes	Thyroid Disease. . . . . no yes
Scarlet Fever. . . . . no yes	Tuberculosis. . . . . no yes	Date of last chest xray _____	Bleeding Tendency. . . . no yes
Diphtheria. . . . . no yes	Diabetes. . . . . no yes	Asthma. . . . . no yes	Any other disease. . . . no yes
Smallpox. . . . . no yes	Cancer. . . . . no yes	Hives or Eczema. . . . . no yes	(please list)
Pneumonia. . . . . no yes	Polio. . . . . no yes	AIDS or HIV+ . . . . . no yes	_____
Rheumatic Fever. . . . . no yes	Glaucoma. . . . . no yes	Infectious Mono. . . . . no yes	
Heart Disease. . . . . no yes	Hernia. . . . . no yes	Bronchitis . . . . . no yes	_____
Arthritis. . . . . no yes	Blood or Plasma	Mitral Valve Prolapse. . . no yes	
Venereal Disease. . . . . no yes	Transfusions. . . . . no yes	Stroke. . . . . no yes	_____

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medications: (Include nonprescription) _____
_____
_____

Patient social history:

Marital Status:	Single:_____	Married:_____	Separated:_____	Divorced:_____	Widowed:_____
Use of alcohol:	Never:_____	Rarely:_____	Moderate:_____	Daily:_____	
Use of tobacco:	Never:_____	Previously, but quit:_____		Current packs/day:_____	
Use of drugs:	Never:_____	Type/Frequency:_____			
Excessive exposure at home or work to:	Fumes:_____	Dust:_____	Solvents:_____	Air-borne Particles:_____	Noise:_____

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father	____	_____	_____
Mother	____	_____	_____
Siblings	____	_____	_____
	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____
	____	_____	_____

Review of Systems: Please indicate any personal history below:

☐ **Constitutional Symptoms**
Good general health lately . . . . . No Yes
Recent weight change . . . . . No Yes
Fever . . . . . No Yes
Fatigue . . . . . No Yes
Headaches . . . . . No Yes
Incontinence or dribbling . . . . No Yes

☐ **Eyes**
Eye disease or injury . . . . . No Yes
Wear glasses/contact lenses . . . .No Yes
Blurred or double vision . . . . . No Yes

Female – irregular periods . . . . No Yes
☐ Female – vaginal discharge . . . No Yes
Hearing loss or ringing . . . . . No Yes
Earaches or drainage . . . . . No Yes
Chronic sinus problem or rhinitis No Yes
Nose bleeds . . . . . No Yes
Mouth sores . . . . . No Yes
Bleeding gums . . . . . No Yes
Bad breath or bad taste . . . . . No Yes
Sore throat or voice change . . . No Yes
Swollen glands in neck . . . . . No Yes

☐ **Cardiovascular**
Heart trouble . . . . . No Yes
Chest pain or angina pectoris . . . No Yes
Palpitation . . . . . .No Yes
Shortness of breath w/ walking
or lying flat . . . . . No Yes
Swelling of feet,ankles or hands . No Yes
Varicose veins . . . . . No Yes

☐ **Respiratory**
Chronic or frequent coughs . . . . . No Yes
Spitting up blood . . . . No Yes
Shortness of breath . . . . . No Yes
Wheezing . . . . No Yes
Known food allergies: _____

☐ **Gastrointestinal**
Loss of appetite . . . . . No Yes
Change in bowel movements . . . No Yes
Nausea or vomiting . . . . . No Yes
Frequent diarrhea . . . . . No Yes
Painful bowel movements
or constipation . . . . . No Yes
Rectal bleeding or blood in stool No Yes
Abdominal pain . . . . . No Yes

☐ **Genitourinary**
Frequent urination . . . . . No Yes
Burning or painful urination . . No Yes
Blood in urine . . . . . No Yes
Change in force of strain
when urinating . . . . . No Yes

Endocrine
Kidney stones . . . . . No Yes
Sexual difficulty . . . . . No Yes
Male – testicle pain . . . . . No Yes
Female – pain with periods . . . No Yes
Change in hat or glove size . . . . . .No Yes

Female - # of pregnancies . . . _____
Female - # of miscarriages . . . _____
Female – date of last pap smear _____

☐ **Musculoskeletal**
Joint pain . . . . . No Yes
Joint stiffness or swelling . . . . . No Yes
Weakness or muscles or joints . No Yes
Muscle pain or cramps . . . . . No Yes
Back pain . . . . . No Yes
Cold Extremities . . . . . No Yes
Difficulty in walking . . . . . No Yes

☐ **Integumentary (skin, breast)**
Rash or itching . . . . . No Yes
Change in skin color . . . . . No Yes
Change in hair or nails . . . . . No Yes
Breast pain . . . . . No Yes
Breast lump . . . . No Yes
Breast discharge . . . . No Yes

☐ **Neurological**
Frequent of recurring headaches .No Yes
Light headed or dizzy . . . . . No Yes
Convulsions or seizures . . . . . No Yes
Numbness or tingling sensations . No Yes
Tremors . . . . . No Yes
Paralysis . . . . . No Yes
Head injury . . . . . No Yes

☐ **Psychiatric**
Memory loss or confusion . . . . . No Yes
Nervousness . . . . . No Yes
Depression . . . . . No Yes
Insomnia . . . . . No Yes

☐
Glandular or hormone problem . No Yes
Excessive thirst or urination . . . . No Yes
Heat or cold intolerance . . . . . No Yes
Skin becoming drier . . . . . No Yes

Ears/Nose/Mouth/Throat

Hematologic/Lymphatic
Slow to heal after cuts . . . . . No Yes
Bleeding or bruising tendency . . No Yes
Anemia . . . . . No Yes
Phlebitis . . . . . No Yes
Past transfusion . . . . . No Yes
Enlarged glands . . . . . No Yes

☐ **Allergic/Immunologic**

History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics . .No Yes
Morphine, Demerol
or other narcotics . . . . . No Yes
Novocain or other anesthetics. No Yes
Aspirin or other pain remedies No Yes
Tetanus antitoxin
or other serums . . . . . No Yes
Iodine, Merthiolate or
or other antiseptic . . . . . No Yes
Other drugs/medications:_____
_____

_____

Environmental allergies: _____
_____

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 services I may need.

_____ _____
Signature of Patient, Parent or Guardian Date

Doctor's Review