

**HEALTH HISTORY**  
(Confidential)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Date of Last Physical Exam \_\_\_\_\_

Referring Physician \_\_\_\_\_ Primary Physician \_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_

**REVIEW OF SYSTEMS**

Constitutional

- Weight loss
- Fever
- Poor sleep

Cardiovascular

- Chest pain
- Palpitations

GU

- Blood in urine
- Urinary retention
- Urinary incontinence

Neurologic

- Slurred speech
- Difficulty swallowing
- Vertigo
- Memory loss
- Focal weakness
- Focal numbness
- Instability of walking

Eyes

- Blurred vision
- Loss of vision
- Double vision
- Eye pain

Respiratory

- Shortness of breath
- Cough
- Sputum

Musculoskeletal

- Muscle pain
- Hand joint pain
- Wrist pain
- Elbow pain
- Shoulder pain
- Hip pain
- Knee pain
- Ankle pain

Skin

- Moles changing size or shape
- Rash
- Wounds that won't heal

ENT

- Decreased hearing
- Sinus discharge
- Sores in mouth
- Ear pain

GI

- Diarrhea
- Constipation
- Blood in stool
- Painful bowel movement
- Fecal incontinence
- Vomiting
- Nausea

**List Chronic Medical Problems For Which You are Treated by Other Physicians:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do You Have a History of:**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Thyroid problems        | <input type="checkbox"/> HIV           |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Gout                    | <input type="checkbox"/> Liver disease |
| Types _____                                     | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Heart beat irregularity | <input type="checkbox"/> Migraines     |
| <input type="checkbox"/> Cataracts              | <input type="checkbox"/> Prostate problems   | <input type="checkbox"/> Heart attack            | <input type="checkbox"/> Polio         |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Kidney stones |

**List Surgeries/Year Performed**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you had:**

- |  |  |
|--|--|
| <input type="checkbox"/> Brain surgery               | <input type="checkbox"/> Pain Medications    |
| <input type="checkbox"/> Neck surgery                | <input type="checkbox"/> Physical Therapy    |
| <input type="checkbox"/> Lumbar spine surgery        | <input type="checkbox"/> Epidural Injections |
| <input type="checkbox"/> Appendectomy                |  |
| <input type="checkbox"/> Gallbladder                 |  |
| <input type="checkbox"/> Tonsillectomy/adenoidectomy |  |
| <input type="checkbox"/> Hysterectomy                |  |

**Medications**


**Allergies**


**Social History**

How many children do you have? \_\_\_\_\_ Are you: Married \_\_\_\_\_ Single \_\_\_\_\_ Other \_\_\_\_\_

Did/Do You Smoke? \_\_\_\_ When did you quit? \_\_\_\_\_ Packs/day smoked? \_\_\_\_ #Years smoked? \_\_\_\_

How much wine/beer/hard liquor do you drink? \_\_\_\_\_

Current Occupation (if retired, former occupation) \_\_\_\_\_

Have you ever used marijuana, cocaine or injectable drugs? \_\_\_\_\_ Last time used? \_\_\_\_\_

**Family History**

	Alive	Deceased	Age at Death	Cause of Death
Mother				
Father				
Brothers				
Sisters				
Children				

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature