

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 | |

OVER

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