HEALTH HISTORY

Date:

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

Name: **Chart #:**
Date of Birth:
Age:

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 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 x-ray _____		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 Transfusions	no yes	Mitral Valve Prolapse	no yes		
Venereal Disease	no yes			Stroke	no yes	_____	

Previous Hospitalizations / Surgeries / Serious Illnesses **When?**

_____ _____

_____ _____

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 a day: _____	
Use of drugs:	Never: _____	Type/Frequency: _____			
Excessive exposure at home or work to:	Fumes: _____	Dust: _____	Solvents: _____	Particles: _____	Noise: _____

Family medical history:

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

Review of Systems: Please indicate any personal history below:

Chart #:

Constitutional Symptoms ☐ NONE

Good general health lately	No Yes
Recent weight change	No Yes
Fever	No Yes
Fatigue	No Yes
Headaches	No Yes

Eyes ☐ NONE

Eye disease or injury	No Yes
Wear glasses/contact lenses	No Yes
Blurred or double vision	No Yes

Ears/Nose/Mouth/Throat ☐ NONE

Hearing loss or ringing	No Yes
Earaches or drainage	No Yes
Chronic sinus problem	No Yes
Nose bleeds	No Yes
Chronic rhinitis	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 ☐ NONE

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 ankles or feet	No Yes

Gastrointestinal ☐ NONE

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 ☐ NONE

Frequent urination	No Yes
Burning or painful urination	No Yes
Blood in urine	No Yes
Change in force of strain when urinating	No Yes
Incontinence or dribbling	No Yes
Kidney stones	No Yes
Female - pain with periods	No Yes
Female - irregular periods	No Yes
Female - vaginal discharge	No Yes
Female - # of pregnancies	_____
Female - # of miscarriages	_____
Female - date of last pap smear	_____
Male - testicle pain	No Yes

Musculoskeletal ☐ NONE

Joint pain	No Yes
Joint stiffness or swelling	No Yes
Weakness of muscles or joints	No Yes
Back pain	No Yes
Cold extremities	No Yes
Difficulty in walking	No Yes
Muscle pain or cramps	No Yes

Integumentary (skin, breast) ☐ NONE

Rash or itching	No Yes
Change in skin color	No Yes
Change in hair or nails	No Yes
Varicose veins	No Yes
Breast pain	No Yes
Breast lump	No Yes
Breast discharge	No Yes

Neurological ☐ NONE

Frequent/recurring headaches	No Yes
Light headed or dizzy	No Yes
Convulsions or seizures	No Yes
Numbness/tingling sensations	No Yes
Tremors	No Yes
Paralysis	No Yes
Head injury	No Yes

Psychiatric ☐ NONE

Memory loss	No Yes
Nervousness	No Yes
Depression	No Yes
Insomnia	No Yes
Confusion	No Yes

Endocrine ☐ NONE

Glandular or hormone problem	No Yes
Excessive thirst	No Yes
Excessive urination	No Yes
Heat/cold intolerance	No Yes
Skin becoming dryer	No Yes
Change in hat/glove size	No Yes

Hematologic/Lymphatic ☐ NONE

Slow to heal after cuts	No Yes
Bleeding tendency	No Yes
Bruising tendency	No Yes
Anemia	No Yes
Phlebitis	No Yes
Past transfusion	No Yes
Enlarged glands	No Yes

Respiratory ☐ NONE

Chronic or freq. coughs	No Yes
Spitting up blood	No Yes
Shortness of breath	No Yes
Wheezing	No Yes

ALLERGIES? NONE

If yes, please list

_____

_____

_____

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.

_____

PATIENT SIGNATURE

_____

PHYSICIAN SIGNATURE