HEALTH HISTORY

PATIENT NAME________________________________ BIRTHDATE_____/______/______ SEX ____M____F

To help us meet all your healthcare needs, please fill out both sides of this form.

Today's Date___________________________________
Highest Level in School _________________________
Occupation _____________________________________
Marital Status __________________________________
Habits:
Smoking (type & amount per day) _________________
If former smoker quit date: _____________________
Alcohol (type & amount per day) _________________
Street drugs (type & amount per day) _____________
Weigh t_______________ Height _________________
Do you exercise regularly? _______________________
Please list all allergies (food, drugs, environment):
____
____
____
____
____

Name of Primary Care Doctor____________________________
please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred _________________None
____
____
____
____
____
____

Please list all medications you are currently taking (include usual non-prescription drugs) ______________None
____
____
____
____
____

CHIEF SYMPTOMS:
Please list the present health concerns, symptoms, or problems you are experiencing:
____
____

PAST MEDICAL HISTORY:
Have you ever had the following prior to a year ago? (Circle "No" or "Yes" leave blank if uncertain)

Depression	Yes No	Migraine Headache	Yes No	Stroke	Yes No
Dementia/Alzheimer's	Yes No	Diabetes	Yes No	COPD/Emphysema	Yes No
Numb/burning feet	Yes No	Cancer	Yes No	Ulcer	Yes No
Parkinson's Disease	Yes No	Glaucoma	Yes No	Kidney Disease	Yes No
Rheumatic Fever	Yes No	Hernia	Yes No	Thyroid Disease	Yes No
Heart Disease	Yes No	Blood Transfusion	Yes No		
Heart Surgery	Yes No	Neck/Back trouble	Yes No	Any Other Diseases:	Yes No
Pacemaker	Yes No	High Blood Pressure	Yes No	______________________________	
Heart Valve Replacement	Yes No	Hemorrhoids	Yes No	______________________________	
Anemia	Yes No	Asthma	Yes No	______________________________	
Epilepsy	Yes No	Bladder Infections	Yes No		
High Cholesterol	Yes No	Drug/Alcohol Problems	Yes No	Cancer:	Yes No
Kidney Stones	Yes No	Vitamin B12 Deficiency	Yes No	What type: ____________________	
Lupus	Yes No	Hepatitis B	Yes No	______________________________	
Rheumatoid Arthritis	Yes No	Hepatitis C	Yes No	______________________________	
Fibromyalgia	Yes No	AIDS/HIV	Yes No	______________________________	

FOR US TO SCHEDULE CERTAIN TESTS, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you have a pacemaker	Yes No	Have you had Heart Valve Replacement	Yes No
Are you Claustrophobic	Yes No	Is there any metal in your body	Yes No
		Where__________________	

FAMILY HISTORY

Has any blood relative had any of the following: (Circle "No or "Yes", leave blank if uncertain)

Condition	Yes/No		Condition	Yes/No	
Brain Tumor	Yes No	________________	Stroke	Yes No	________________
Cancer	Yes No	________________	Epilepsy/Seizures	Yes No	________________
Tuberculosis	Yes No	________________	Anemia	Yes No	________________
Diabetes	Yes No	________________	Bleeding Tendency	Yes No	________________
Heart Disease	Yes No	________________	Chronic Lung Disease	Yes No	________________
High Blood Pressure	Yes No	________________	Dementia/Alzheimer's	Yes No	________________
Asthma	Yes No	________________	Thyroid Disease	Yes No	________________
Drug/Alcohol Problems	Yes No	________________	Kidney Disease	Yes No	________________
Depression	Yes No	________________	Neck/Back Trouble	Yes No	________________
Migraine Headache	Yes No	________________	Numb/Burning Feet	Yes No	________________
Ulcer	Yes No	________________	Multiple Sclerosis	Yes No	________________
High Cholesterol	Yes No	________________	ALS/Lou Gehrig's disease	Yes No	________________
Parkinson's	Yes No	________________	Peripheral Neuropathy	Yes No	________________
Tremor	Yes No	________________	Carpal Tunnel Syndrome	Yes No	________________

CURRENT MEDICAL HISTORY:

Do you have NOW or have you had within the PAST YEAR:
(Circle "No" or "Yes", leave blank if uncertain)

Fatigue	Yes No	Bloody Sputum	Yes No	Blood in Urine	Yes No
Wheezing	Yes No	Joint pain or Stiffness	Yes No	Hemorrhoids	Yes No
Recent Weight Gain	Yes No	Chest Pain or Discomfort	Yes No	Tremor	Yes No
Recent Weight Loss	Yes No	Difficulty Breathing	Yes No	Backaches	Yes No
Change in Appetite	Yes No	Palpitations or fluttering		Swollen Joints	Yes No
Sensitivity to Cold	Yes No	of the heart	Yes No	Sleeplessness	Yes No
Sensitivity to Heat	Yes No	Legs Cramping at Night	Yes No	Seizures	Yes No
Persistent High Fever	Yes No	Walking	Yes No	Depression	Yes No
Skin Rash	Yes No	Difficulty Swallowing	Yes No	Loss of	
Loss/Thinning Hair	Yes No	Heartburn	Yes No	Consciousness	Yes No
Headaches	Yes No	Frequent Belching	Yes No	(Passing-out)	
Easy Bleeding /Bruising	Yes No	Abdominal Cramping	Yes No	Memory Loss	Yes No
Blurred Vision	Yes No	Nausea	Yes No	Poor Coordination	Yes No
Double Vision	Yes No	Vomiting	Yes No	Dizziness	Yes No
Ringing in Ears	Yes No	Coughing up Blood	Yes No	MEN ONLY	
Discharge from ears	Yes No	Chronic Diarrhea	Yes No	Discharge from	
Ear Pain	Yes No	Chronic Constipation	Yes No	Penis	Yes No
Decrease in Hearing	Yes No	Rectal Bleeding	Yes No	Pain or Lump in	
Frequent Nosebleeds	Yes No	Dark Urine	Yes No	Testicles	Yes No
Sinus Trouble	Yes No	Frequent Urination-Day	Yes No	Impotence	Yes No
Persistent Hoarseness	Yes No	Frequent Urination-Night	Yes No		
Lump in Breast	Yes No	Increased Thirst	Yes No	WOMEN ONLY	
Discharge from Breast	Yes No	Painful Urination	Yes No	Do you bleed or spot	
Chronic/Frequent Cough	Yes No	Leakage of Urine-with		between periods	Yes No
Lack of Sex Drive	Yes No	w/coughing/straining	Yes No	Date of Last Period ________________	
Numbness in Feet	Yes No	Leakage of Urine at night	Yes No	Do you have pain/cramps ____________	
Numbness in Hands	Yes No	Leakage of Urine (Unable		Date of Last Mammogram____________	
Burning Pain in Feet	Yes No	to get to the bathroom)	Yes No	Type of Birth Control Used____________	
Burning Pain in Hands	Yes No	Balance Problems	Yes No	Number of Pregnancies ____________	
				Number of Full-term births____________	
				Number of Pre-term births ____________	

Do you have a Living Will/Advanced Directive: Yes No

X____ _________________________________

Signature of Patient (or Parent, if Minor) Date