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(CONFIDENTIAL)

HEALTH HISTORY

WELCOME! IT IS TIME TO UPDATE YOUR HEALTH HISTORY
PLEASE COMPLETE BOTH SIDES OF THIS FORM.

NAME ______________________ (LAST) ______________________ (FIRST) ______________________ (MIDDLE) AGE ______ DATE ____________

HAS THERE BEEN ANY SIGNIFICANT CHANGE IN YOUR HEALTH IN THE LAST YEAR?
(YES / NO) ________ (IF SO / TELL US ABOUT IT)

HAVE YOU BEEN UNDER THE CARE OF ANY OTHER DOCTOR IN THE LAST YEAR?
(YES / NO) ________ (PLEASE GIVE DOCTORS NAME AND REASON FOR VISIT)

HAVE ANY OF YOUR FAMILY MEMBERS HAD SIGNIFICANT HEALTH PROBLEMS IN THE LAST YEAR?
(YES / NO) ________ (IF SO, PLEASE MENTION WHO WAS SICK AND WHAT PROBLEM THEY HAVE / HAD.)

INFORMATION WE NEED TO HELP KEEP YOU HEALTHY:

DO YOU SMOKE CIGARETTES? _____ HOW MANY PACKS A DAY? _____ HOW MANY YEARS? _____
DID YOU EVER SMOKE? _____ IF YOU QUIT, TELL US WHEN ____________________
HOW MANY PACKS A DAY _____

DO YOU USE ANY
OTHER TOBACCO PRODUCTS? _____ (CHEW, CIGAR, PIPE, SNUFF, ETC.)

DO YOU DRINK ALCOHOL? _____ IF SO / HOW MANY DRINKS A DAY? _____
CHECK HERE IS ONLY OCCASIONALLY _____

DO YOU USE HERBAL MEDICINES?_____ IF SO, WHAT? ____________________

DO YOU USE ANY
RECREATIONAL DRUGS? _____
(CHECK THOSE THAT APPLY MARIJUANA____ COCAINE____ SPEED ____ LSD____ OTHER____

EVER USE IV DRUGS _____ (ALL INFORMATION ON THIS FORM IS CONFIDENTIAL)

EVER HAD A
BLOOD TRANSFUSION? _____ WHEN / WHY____________________

WHEN WAS YOUR LAST TETANUS SHOT? ____________

WHAT KINDS OF FOOD DO YOU EAT? (CHECK THOSE THAT APPLY)

RED MEAT OFTEN _____ OCCCASIONALLY_____ NEVER_______
FRUIT AND VEGETABLES OFTEN_____ OCCCASIONALLY_____ NEVER_______
LOW FAT DIET (YES / NO) _____
LOW SALT DIET (YES / NO) _____
HOW MANY CUPS OF REGULAR COFFEE OR CAFFEINATED BEVERAGES
(TEA, COKE ETC.) DO YOU DRINK A DAY ?______

WHAT IS YOUR OCCUPATION?____________________
HOW MANY HOURS PER WEEK?_________ WHAT SHIFT?_______
ARE YOU EXPOSED TO CHEMICALS OR FUMES______
ARE YOU UNDER ALOT OF STRESS?______ AT WORK?_____ HOME?_____OTHER?______
DO YOU WEAR YOUR SEATBELT? ______ DO YOU EXERCISE?______

(OVER)

CHECK IF EXPERIENCING ANY OF THE BELOW IN THE PAST YEAR:

___ UNEXPECTED WEIGHT LOSS
___ UNEXPECTED WEIGHT GAIN
___ MORE THIRSTY LATELY
___ TIREDNESS/WEAKNESS
___ FEVERS/CHILLS
___ NIGHT SWEATS
___ FEELING HOTTER
___ FEELING COLDER
___ HOT FLASHES
___ SNORING
___ APNEA/QUITTING BREATHING

___ BLURRED VISION
___ DOUBLE VISION
___ EYE PAIN OR ITCH
___ REDNESS
___ CATARACTS
___ FLASHING LIGHTS
___ EXCESSIVE TEARING
___ GLASSES
___ LAST EYE CHECK WAS IN
___ TEMPORARY BLINDNESS
___ COLORED HALO

___ HEARING PROBLEMS
___ HEARING AIDS
___ VERTIGO
___ RINGING IN EARS
___ EAR PAIN

___ RUNNY NOSE
___ STUFFINESS
___ BLEEDING FROM NOSE
___ SINUS TROUBLE

___ FREQUENT SORE THROAT
___ BLEEDING GUMS
___ SWELLING OF GUMS
___ HOARSENESS
___ VOICE CHANGE
___ DENTURES
___ SORES IN MOUTH
___ BAD BREATH

___ ANEMIA
___ TRANSFUSION
___ TRANSFUSION REACTIONS

___ DIFFICULTY SWALLOWING
___ PAIN WHILE SWALLOWING
___ THYROID PROBLEM
___ NECK STIFFNESS
___ NECK PAIN
___ SWOLLEN GLANDS

___ COUGH
___ PHLEGM
___ HEMOPTYSIS
___ WHEEZING
___ SHORTNESS OF BREATH
___ ABNORMAL CHEST XRAY
___ POSITIVE TB TEST

___ CHEST PAIN
___ PALPITATION
___ RACING HEART/PALPITATION
___ IRREGULAR HEART BEATS
___ SWELLING OF LEGS
___ NEED TWO PILLOWS TO SLEEP
___ FEET/HANDS COLD/BLUE
___ PACEMAKER
___ MURMUR
___ NEED FOR ANTIBIOTICS BEFORE DENTAL VISIT

___ HEARTBURN
___ STOMACH PAINS
___ BLOATING
___ NAUSEA
___ VOMITING
___ DIARRHEA
___ CONSTIPATION
___ BLACK STOOLS
___ BLOOD IN BM
___ HEPATITIS
___ PANCREATITIS
___ JAUNDICE
___ PAIN IN ANUS

___ SKIN RASH
___ ITCHING
___ MOLE CHANGE
___ MOLE REMOVAL
___ SKIN CANCER
___ SKIN LUMPS
___ EASY BRUISING
___ HIVES

___ FREQUENCY
___ DYSURIA
___ HEMATURIA
___ NOCTURIA
___ URGENCY
___ HESITANCY
___ DRIBBLING
___ INCONTINENCE
___ KIDNEY STONES

___ LEG SWELLING
___ LEG CRAMPS
___ RESTLESS LEGS
___ LEG PAINS AFTER WALK
___ VARICOSE VEINS
___ BLOOD CLOTS IN PAST

___ MUSCLE PAINS
___ JOINT PAINS-WHICH ONES-
___ JOINT STIFFNESS
___ BACKACHE
___ SHOOTING PAINS IN LEGS
___ NECK PAIN

___ HIGH CHOLESTEROL
___ HIGH TRIGLYCERIDES
___ DIABETES MELLITUS
___ POTASSIUM PROBLEMS

___ MEMORY PROBLEMS
___ HALLUCINATIONS
___ DEPRESSION
___ ANXIETY
___ PANIC ATTACKS
___ MEMORY PROBLEMS
___ MOOD SWINGS
___ CRY OFTEN
___ LONELY
___ LOSS OF APPETITE
___ WORRY A LOT
___ TREATMENT- ABOVE IN PAST

___ SEVERE HEADACHES
___ FAINTING
___ DIZZINESS/LIGHTHEADEDNESS
___ STROKE/PARALYSIS
___ MINI STROKE/TIA
___ TINGLING
___ NUMBNESS
___ TREMORS
___ SPEECH PROBLEMS
___ HEAD INJURY

PLEASE LIST ALL MEDICATIONS THAT YOU TAKE ON REGULAR BASIS INCLUDING PRESCRIPTIONS, NON-PRESCRIPTION, HERBS, VITAMIN

ANY DRUG ALLERGIES? YES NO LIST

ANY BEE STING ALLERGIES? YES NO

ANY FOOD ALLERGIES? YES NO

ANY OTHER HEALTH ISSUES:

FOR WOMEN

___ BREAST LUMPS
___ BREAST PAIN
___ BREAST DISCHARGE
___ BREAST BIOPSIES
___ ABNORMAL MAMMOGRAMS
___ BLEEDING FROM NIPPLE
___ IRREGULAR PERIODS
___ SPOTTING
___ HEAVY BLEEDING
___ SEVERE CRAMPS
___ VAGINAL DISCHARGE
___ USE OF HORMONES

___ LAST PERIOD
___ NUMBER OF PREGNANCIES
___ ARE YOU PREGNANT NOW
___ TYPE OF CONTRACEPTION
___ IF MENOPAUSE WHEN?_____
___ HYSTERECTOMY?_____
___ DO YOU DO BREAST SELF EXAMS?_____
___ LOSS OF SEX DRIVE
___ HOT FLASHES
___ VAGINAL DRYNESS

FOR MEN

___ SORES ON PENIS
___ DISCHARGE FROM PENIS
___ PROSTATE PROBLEMS
___ DIFFICULTY URINATING
___ PROBLEMS WITH ERECTION
___ UP MORE THAN TWICE IN NIGHT TO URINATE

I CERTIFY THAT MY ANSWERS TO THESE QUESTIONS ARE ACCURATE AND WILL NOT HOLD THE DOCTOR OR MEDICAL STAFF RESPONSIBLE FOR OMMISSIONS.

X ______________________ ______________

PATIENT SIGNATURE DATE