

Patient Health History

Name: _____
SSN: _____

Date: _____
DOB: _____

Chief Complaint: What is the reason for your visit today? (Please describe problem in detail including history of present illness): _____

Past Medical History: Please check all that apply to you:

- | | | |
|-------------------------------------|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Psychiatric disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> None |

Previous Surgeries: Please list past surgeries with approximate date: _____

Serious Injury: Please describe any serious injuries you have had: _____

Medications: Please list any medications you are taking with dose and frequency:

<i>Drug</i>	<i>Dose/Frequency</i>
_____	_____
_____	_____
_____	_____

Allergies: please list any allergies that you have _____

Social History:

Do you drink alcohol? Yes No If yes, how much/week? _____
Do you smoke? Yes No If yes, how many cigarettes/day? _____
Do you consume caffeine? Yes No If yes, how many cups/week? _____
Do you use recreation drugs? Yes No If yes, what type and frequency? _____
Are you on a special diet? Yes No If yes, please describe? _____

Family History: Do you know of any blood relative who has or had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Disease |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer, Type: | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> None |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Migraine | |

Comments:

Patient Health History

As you review the following list, please check any problems or conditions, that you are experiencing or have experienced. If you do not have any of the problems listed in the section please check none.

General Health

- Good general health
- Recent weight change
- Loss of appetite
- Fatigue
- Fever/chills

Allergy

- Drug allergies
- Food allergies
- Hay fever
- Other: _____
- None

Ears, Nose, Mouth, Throat

- Difficulty swallowing
- Earaches
- Loss of hearing/deafness
- Loss of smell
- Loss of taste
- Painful chewing
- Ringing in ears
- Sinus infection
- Sores in mouth
- None
- Other: _____

Eyes

- Blind spots
- Blurred vision
- Double vision
- Loss of vision
- Glaucoma
- Injury
- Pain
- Other: _____
- None

Gastrointestinal

- Blood in stools
- Increasing constipation
- Nausea
- Painful bowel movements
- Persistent diarrhea
- Stomach or abdominal pain
- Ulcer
- Vomiting
- Other: _____
- None

Genitourinary

- Blood in urine
- Female: irregular periods
- Female: #pregnancies _____
#miscarriages _____
- Female: vaginal discharge
- Kidney stones
- Male: prostate disease
- Male: testicle pain
- Painful or burning urination
- Sexual difficulty
- Sexually transmitted disease
- Urgency with urination
- Urine retention/
incontinence
- Other: _____
- None

Heart and Lungs

- Pain in chest
- High blood pressure
- High cholesterol
- Irregular heart beat
- Other: _____
- None

Muscles/Joints/Bones

- Back pain
- Difficulty walking
- Joint pain
- Joint stiffness or swelling
- Muscle pain or tenderness
- Neck pain
- None

Neurological

- Balance trouble
- Black outs/loss of
consciousness
- Difficulty speaking
- Difficulty walking
- Facial drooping
- Headaches
- Injury to the brain or spine
- Light-headed or dizziness
- Memory loss
- Mental Confusion
- Migraines
- Mini stroke

- Neuropathy
- Numbness or tingling
- Paralysis
- Stroke
- Tremors
- Weakness
- Other: _____
- None

Are you? right handed
 left handed
 Both

Psychiatric

- Depression
- Anxiety
- Eating disorder
- Other: _____
- None

Pulmonary

- Asthma
- Blood in cough
- Cancer
- Chronic or frequent cough
- Emphysema
- Pneumonia
- Shortness of breath
- Other: _____
- None

Skin

- Rash or itching
- Sun sensitivity
- Hair loss
- Color changes
- Other: _____
- None

Sleep

- Snoring
 - Sleepwalking
 - Nightmares
- Do you sleep well? Yes No
- Do you feel rested when you wake? Yes No
- Do you fall asleep during the day? Yes No