

HEALTH HISTORY

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

Date: _____

Patient Name _____ Birthdate _____ Patient # _____

Chief Complaint: _____

History of present illness:

Location: _____
(Where is the pain/problem?)

Severity _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Timing _____
(Does the pain/problem occur at a specific time?)

Associated signs/symptoms _____

(What other associated problems have you been having?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Duration _____
(How long have you had this pain/problem?, or, When did it start?)

Context _____
(Where were you at the onset of this pain/problem?)

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 | | | Mitral Valve Prolapse ... | no | yes | _____ | | |
| Venereal Disease | no | yes | Transfusions | no | yes | Stroke | no | yes | _____ | | |

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription) _____

Have you ever taken Fen-Phen/Redux? no yes

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

Family medical history:

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

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms

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

Eyes

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

Ears/Nose/Mouth/Throat

Hearing loss or ringing No Yes
 Earaches or drainage No Yes
 Chronic sinus problem or rhinitis No Yes
 Nose bleeds 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

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 feet, ankles or hands No Yes

Respiratory

Do you have a persistent cough
 or throat clearing not associated
 with a known illness (lasting more
 than 3 weeks)? No Yes
 Spitting up blood No Yes
 Shortness of breath No Yes
 Wheezing No Yes

Gastrointestinal

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

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
 Sexual difficulty No Yes
 Male - testicle pain 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 _____

Musculoskeletal

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

Integumentary (skin, breast)

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

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

Psychiatric

Memory loss or confusion No Yes
 Nervousness No Yes
 Depression No Yes
 Insomnia No Yes

Endocrine

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

Hematologic/Lymphatic

Slow to heal after cuts No Yes
 Bleeding or bruising tendency . . No Yes
 Anemia No Yes
 Phlebitis No Yes
 Past transfusion No Yes
 Enlarged glands No Yes

Allergic/Immunologic

History of skin reaction or other adverse
 reaction to:
 Penicillin or other antibiotics . No Yes
 Morphine, Demerol,
 or other narcotics No Yes
 Novocain or other anesthetics No Yes
 Aspirin or other pain remedies No Yes
 Tetanus antitoxin
 or other serums No Yes
 Iodine, Merthiolate or
 other antiseptic No Yes
 Other drugs/medications: _____

Known food allergies: _____

Environmental allergies: _____

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.

 Signature of Patient, Parent or Guardian

 Date

Doctor's Review

 Signature of Doctor

 Date