

Patient Name: _____

Date: _____

HEALTH HISTORY

PAST HEALTH PROBLEMS

Please indicate if you have experienced any of the following health problems

<u>Illness</u>	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Glaucoma	_____	_____	Hemorrhoids	_____	_____
Cataracts	_____	_____	Kidney or Bladder	_____	_____
Ear Trouble	_____	_____	Prostrate	_____	_____
Deafness	_____	_____	Headaches/Migraines	_____	_____
Thyroid Trouble	_____	_____	Head Injury	_____	_____
Bronchitis	_____	_____	Stroke	_____	_____
Emphysema	_____	_____	Convulsions/Seizures	_____	_____
Pneumonia	_____	_____	Arthritis	_____	_____
Hay Fever	_____	_____	Gout	_____	_____
Asthma	_____	_____	Psoriasis	_____	_____
Tuberculosis	_____	_____	Eczema	_____	_____
High Blood Pressure	_____	_____	Cancer/Tumor	_____	_____
Heart Attack	_____	_____	Anemia	_____	_____
Hardening of Arteries	_____	_____	Bleeding Tendency	_____	_____
Heart Murmurs	_____	_____	Blood Transfusion	_____	_____
High Cholesterol	_____	_____	Diabetes	_____	_____
Ulcer	_____	_____	Polio	_____	_____
Bowel Problems	_____	_____	Depression	_____	_____
Hepatitis	_____	_____	Dental Problems	_____	_____
Gall Bladder	_____	_____	OTHER _____		
Mental Health Problems	_____	_____	_____		
Alcoholism/Drug Problems	_____	_____	_____		

MEDICATIONS: _____

MEDICATION ALLERGIES:

HEALTH BEHAVIORS

Tobacco Use? Yes ___ No ___
Packs Per Day ___
Years ___

Alcohol/Drug Use? Yes ___ No ___
Amount Per Day ___
Days Per Week ___

Do you use your seatbelt regularly?
Yes ___ No ___

Do you exercise regularly
Yes ___ No ___

Do you brush your teeth? Yes ___ No ___ Floss your teeth? Yes ___ No ___ Last Dental Visit _____

HOSPITALIZATIONS/SURGERIES

<u>Year</u>	<u>Reason</u>	<u>Hospital and City</u>

HEALTH PROBLEMS IN THE LAST YEAR (Check YES or NO if known. Leave blank if unknown.)

GENERAL	YES	NO	GENERAL	YES	NO
Black or bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Blood in vomit	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps while walking	<input type="checkbox"/>	<input type="checkbox"/>
Bothered by heat or cold	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Breathless at night	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>
Breathless with walking	<input type="checkbox"/>	<input type="checkbox"/>	Occasionally lose urine and get wet	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	Painful joints	<input type="checkbox"/>	<input type="checkbox"/>
Burning urination	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations / irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	Pass urine more than twice at night	<input type="checkbox"/>	<input type="checkbox"/>
Change in sleep	<input type="checkbox"/>	<input type="checkbox"/>	Problems with memory	<input type="checkbox"/>	<input type="checkbox"/>
Change in walking	<input type="checkbox"/>	<input type="checkbox"/>	Shaking or trembling in hands	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain / discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Skin problems (rash, itch)	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Sleeps sitting up	<input type="checkbox"/>	<input type="checkbox"/>
Cough / phlegm most days	<input type="checkbox"/>	<input type="checkbox"/>	Soiling from bowels	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing problems	<input type="checkbox"/>	<input type="checkbox"/>
Decreased energy	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in legs / feet	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	Urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>
Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Urinary infection history	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Visual Loss	<input type="checkbox"/>	<input type="checkbox"/>
Easily Bleeds / bruises	<input type="checkbox"/>	<input type="checkbox"/>	Weakness on one side of body	<input type="checkbox"/>	<input type="checkbox"/>
Fainting or passing out	<input type="checkbox"/>	<input type="checkbox"/>	Weight Change	<input type="checkbox"/>	<input type="checkbox"/>
Falls	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Fevers/Chills	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HEALTH HISTORY

Have any **immediate** family members had any of the following illnesses? If so, please indicate relationship (mother, father, sister, grandparents, children)

<u>Illness</u>	<u>Family Members</u>	<u>Illness</u>	<u>Family Members</u>
High Blood Pressure	_____	Epilepsy	_____
Heart Disease	_____	Rheumatoid Arthritis	_____
Stroke	_____	Gallbladder Disease	_____
Cancer	_____	Colitis/Irritable Bowel	_____
Diabetes	_____	Migraine Headaches	_____
Asthma/Emphysema	_____	Mental Health Problems	_____
Tuberculosis	_____	Depression	_____
Cystic Fibrosis	_____	Suicide	_____
Blood Disease	_____	Alcoholism	_____
Multiple Sclerosis	_____	Other	_____