

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 _____ Birth date _____ 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 "yes" or "no", leave blank if uncertain)

Measles.....	no	yes	Anemia.....	no	yes	Back Trouble.....	no	yes	Hepatitis.....	no	yes
Mumps.....	no	yes	Mitral Valve Prolapse.....	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	Asthma.....	no	yes	Thyroid Disease.....	no	yes
Scarlet Fever.....	no	yes	Tuberculosis.....	no	yes	Hives or Eczema.....	no	yes	Reflux (GERD).....	no	yes
Diphtheria.....	no	yes	Diabetes.....	no	yes	AIDS or HIV+.....	no	yes	Organ Transplant.....	no	yes
Polio.....	no	yes	Cancer.....	no	yes	Infectious Mono.....	no	yes	Any Other Disease (please list)	_____	
Rheumatic Fever.....	no	yes	Stroke.....	no	yes	Bronchitis.....	no	yes	_____	_____	
Heart Disease.....	no	yes	Glaucoma.....	no	yes	Blood or Plasma			_____	_____	
Arthritis.....	no	yes	Hernia.....	no	yes	Transfusions.....	no	yes	_____	_____	

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

Medications: (Include nonprescription, vitamins and dietary supplements)

Are you either pregnant or nursing Yes No N/A

Patient social history:

Marital status Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of tobacco: Never: _____ Previously, but quit & when: _____ Current packs/day: _____

Age you started smoking: _____

Use of drugs: Never: _____ Type/Frequency: _____

Excessive exposure

At home or work to: Fumes: _____ Dust: _____ Solvents: _____ Particles: _____ Noise: _____

Family medical history:

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

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

• Eyes

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

• Ear/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
 Bell's Palsy or
 Paralyzed Facial Nerve..... No Yes
 Difficulty breathing through nose. 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
 Heart Rhythm problem..... No Yes

• Respiratory

Chronic or frequent coughs..... No Yes
 Spitting up blood..... No Yes
 Shortness of breath..... No Yes
 Wheezing..... No Yes

• Gastrointestinal

Loss of appetite..... No Yes
 Nausea or vomiting..... No Yes
 Frequent diarrhea..... No Yes
 Take Tums, Roloids, Nexium,
 Prevacid, Aciphex, Prilosec, Axid,
 Maalox, Pepto-bismol, Zantac
 or Tagamet..... No Yes

• Genitourinary

Frequent urination..... No Yes
 Blood in urine..... No Yes
 Change in force of stream
 when urinating..... No Yes
 Kidney stones..... No Yes
 Sexual difficulty..... No Yes

• Musculoskeletal

Joint pain..... No Yes
 Stiffness or swelling..... No Yes
 Weakness of muscles or joints..... No Yes
 Muscle pain or cramps..... No Yes

• Integumentary (skin, breast)

Rash or itching..... No Yes
 Change in skin color, moles or
 birthmarks..... No Yes
 Change in hair or nails..... No Yes
 Excessive wrinkling, sagging skin. 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
 If yes, Arms, Hands or feet _____
 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

Excessive thirst or urination..... No Yes
 Heat or cold intolerance..... No Yes
 Skin becoming dryer..... No Yes
 Change in hat, glove or collar size. No Yes

• Hematologic/Lymphatic

Slow to heal after cuts..... No Yes
 Bleeding or bruising tendency..... No Yes
 Enlarged lymph glands..... No Yes

• Sleep Disorders

Snoring..... No Yes
 Sleep Apnea..... No Yes
 Well rested on awakening..... No Yes
 Drowsy while driving..... No Yes
 Fallen asleep while driving or
 while in a business meeting..... No Yes
 Awakened by gasping or
 choking spells..... No Yes
 Hour of going to sleep _____
 Hour of awakening _____
 Up how many hours per night _____

• Allergic/Immunologic

History of skin reaction or other adverse
 reaction to:
 Which: _____
 Penicillin or other antibiotics..... No Yes
 Morphine, Demerol
 or other narcotics..... No Yes
 Which: _____
 Novocain or other anesthetics..... No Yes
 Aspirin or other pain remedies... No Yes
 Tetanus antitoxin or
 other serums..... No Yes
 Iodine, Betadine, IV Contrast dye. No Yes
 Other drug allergies or reactions:

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
Doctor's Review

Date

Signature of Doctor

Date