

Health History

Date: _____

Patient: _____ Date of Birth: _____ Age: _____

Referred By: _____



ALLERGIES: _____ _____ _____ _____
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Previous Hospitalizations/Surgeries/Serious Injury Date

Current Medications/Dosage/Directions

Patient social history:

Occupation: _____ Spouse name: _____

Marital status: Single____ Married____ Separated____ Divorced ____ Widowed ____

Use of alcohol: Never____ Rarely ____ Moderate ____ Daily ____

Use of tobacco: Never____ Previously, quit date _____ Current packs/day _____

Use of drugs: Never____ Type/Frequency:

Family medical history

	Age	Diseases	If deceased, cause of death
Father	_____		
<hr/>			
Mother	_____		
<hr/>			
Siblings	_____		
<hr/>			

<hr/>			

<hr/>			
Children	_____		
<hr/>			

<hr/>			

<hr/>			
Spouse	_____		
<hr/>			



REVIEW OF SYSTEMS

CONSTITUTIONAL

- | Neg | Pos | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Good general health |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained weight change |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Chills |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Night sweats |

Other positives _____

EYES/EARS/NOSE/THROAT

- | Neg | Pos | |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Disease or injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Glasses or contacts |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Cataracts |
| <input type="checkbox"/> | <input type="checkbox"/> | Head trauma |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision changes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing in ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Earaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear drainage |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic sinus problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic rhinitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Nose bleeds |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth sores |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding gums |
| <input type="checkbox"/> | <input type="checkbox"/> | Bad breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore throat |
| <input type="checkbox"/> | <input type="checkbox"/> | Voice change |
| <input type="checkbox"/> | <input type="checkbox"/> | Lump in neck |

Other positives _____

CARDIOVASCULAR

- | Neg | Pos | |
|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypertension |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina pectoris |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots |
| <input type="checkbox"/> | <input type="checkbox"/> | Palpitations or racing heart |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling of feet, ankles or hands |

Cardiac testing:
 EKG date ____/____/____
 Echo date ____/____/____

Stress Test date ____/____/____
 Angiogram date ____/____/____
 Other positives _____

RESPIRATORY

- | Neg | Pos |
|--|--|
| <input type="checkbox"/> | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> Coughing at night |
| <input type="checkbox"/> | <input type="checkbox"/> Spitting up blood |
| <input type="checkbox"/> | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> | <input type="checkbox"/> Daytime sleepiness |
| <input type="checkbox"/> | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> | <input type="checkbox"/> Using CPAP/BIPAP |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Is CPAP/BIPAP working |
| Other positives _____ | |

GASTROINTESTINAL

- | Neg | Pos |
|--|--|
| <input type="checkbox"/> | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> | <input type="checkbox"/> Painful bowel movements |
| <input type="checkbox"/> | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> Frequent diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> Rectal bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> Black tarry stools |
| <input type="checkbox"/> | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> Loss of appetites |
| <input type="checkbox"/> | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> | <input type="checkbox"/> Peptic ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Family history of colon cancer |
| Colonoscopy date ____/____/____ | |
| Upper Endoscopy date ____/____/____ | |
| Other positives _____ | |

GENITOURINARY

- | Neg | Pos |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> | <input type="checkbox"/> Intermittent urinary stream |
| <input type="checkbox"/> | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> | <input type="checkbox"/> Sexual difficulty |
| <input type="checkbox"/> | <input type="checkbox"/> Pain with periods |
| <input type="checkbox"/> | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> | <input type="checkbox"/> Vaginal discharge |

Pap smear date ____/____/____
of pregnancies _____
of miscarriages _____
Other positives _____

MUSCULOSKELETAL

Neg	Pos
<input type="checkbox"/>	<input type="checkbox"/> Joint pain
<input type="checkbox"/>	<input type="checkbox"/> Joint stiffness
<input type="checkbox"/>	<input type="checkbox"/> Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Gout
<input type="checkbox"/>	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/>	<input type="checkbox"/> Muscle cramping
<input type="checkbox"/>	<input type="checkbox"/> Back pain
<input type="checkbox"/>	<input type="checkbox"/> Difficulty walking
<input type="checkbox"/>	<input type="checkbox"/> Cold extremities

Other positives _____

INTEGUMENTARY

Neg	Pos
<input type="checkbox"/>	<input type="checkbox"/> Rash
<input type="checkbox"/>	<input type="checkbox"/> Itchy skin
<input type="checkbox"/>	<input type="checkbox"/> Change in skin
<input type="checkbox"/>	<input type="checkbox"/> Change in nails
<input type="checkbox"/>	<input type="checkbox"/> Suspicious moles or spots
<input type="checkbox"/>	<input type="checkbox"/> Skin sores
<input type="checkbox"/>	<input type="checkbox"/> Varicose veins

Other positives _____

BREAST

Neg	Pos
<input type="checkbox"/>	<input type="checkbox"/> Skin changes
<input type="checkbox"/>	<input type="checkbox"/> Breast pain
<input type="checkbox"/>	<input type="checkbox"/> Breast lump
<input type="checkbox"/>	<input type="checkbox"/> Breast discharge

Yes No Family Hist. of breast cancer
Who _____
Mammogram date ____/____/____
Other positives _____

NEUROLOGICAL

Neg	Pos
<input type="checkbox"/>	<input type="checkbox"/> Dizziness
<input type="checkbox"/>	<input type="checkbox"/> Seizures
<input type="checkbox"/>	<input type="checkbox"/> Numb/tingling sensation
<input type="checkbox"/>	<input type="checkbox"/> Tremors
<input type="checkbox"/>	<input type="checkbox"/> Stroke
<input type="checkbox"/>	<input type="checkbox"/> Paralysis
<input type="checkbox"/>	<input type="checkbox"/> Blackouts/fainting

Other positives _____

PSYCHIATRIC

- | Neg | Pos |
|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> Depression |
| <input type="checkbox"/> | <input type="checkbox"/> Insomnia |

Other positives _____

METABOLIC/ENDOCRINE

- | Neg | Pos |
|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Gland/hormonal problem |
| <input type="checkbox"/> | <input type="checkbox"/> Hyperthyroid |
| <input type="checkbox"/> | <input type="checkbox"/> Hypothyroid |
| <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> Diet controlled |
| <input type="checkbox"/> | <input type="checkbox"/> Medication controlled |
| <input type="checkbox"/> | <input type="checkbox"/> Insulin controlled |
| <input type="checkbox"/> | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> | <input type="checkbox"/> Cold intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> Heat intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> Dry skin |

Other positives _____

HEMATOLOGIC

- | Neg | Pos |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Slow to heal after cuts |
| <input type="checkbox"/> | <input type="checkbox"/> Bleeding tendency |
| <input type="checkbox"/> | <input type="checkbox"/> Bruising tendency |
| <input type="checkbox"/> | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> | <input type="checkbox"/> Past transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> Enlarged glands |

Other positives _____

ALLERGIC/IMMUNOLOGIC

- | Neg | Pos |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Lupus/Autoimmune disorder |
- Skin or other adverse reaction to:
- | | |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Penicillin or other antibiotics |
| <input type="checkbox"/> | <input type="checkbox"/> Morphine, Demerol, or other narcotics |
| <input type="checkbox"/> | <input type="checkbox"/> Novocaine or other anesthetics |
| <input type="checkbox"/> | <input type="checkbox"/> Aspirin or other pain remedies |
| <input type="checkbox"/> | <input type="checkbox"/> Tetanus antitoxins or other serums |
| <input type="checkbox"/> | <input type="checkbox"/> Iodine, Methiolate, or other antiseptic |

Other drugs/medications _____

Known food allergies _____

Other positives _____

Patient Signature

Date