HEALTH HISTORY

Name: _____ **DOB:** _____

Home Phone: _____ **WorkPhone:** _____

Current Medications					
Medication	**Dose**	**How often**	**Medication**	**Dose**	**How often**

Do you take? ☐ Herbal Products ☐ Vitamins ☐ Nutrition supplements ☐ NSAIDs (Advil, Motrin, etc)

Allergies ☐ **None** (list allergies below)			
Medication	**Reaction** (Rash, hives, etc)	**Medication**	**Reaction** (Rash, hives, etc)

☐ High blood pressure	☐ Diabetes	☐ Asthma	☐ Kidney Stones
☐ Heart Attack	☐ Cancer _____	☐ Emphysema	☐ Urinary Tract Infection
☐ Heart Disease (other)	☐ HIV/AIDS	☐ Anemia	☐ Other Kidney Disease
☐ Stroke	☐ Thyroid disease	☐ Sickle Cell disease	☐ Liver disease
☐ Other			

Past Surgeries (list with year of surgery)			
Surgery	**Date**	**Surgery**	**Date**

Family History

Relation	Living?	Age	High BP	Heart Dis.	Stroke	Cancer	Kidney Problems	Other (describe)
Father	Y / N		☐	☐	☐	☐	☐	
Mother	Y / N		☐	☐	☐	☐	☐	
Brother/Sister								
M / F	Y / N		☐	☐	☐	☐	☐	
M / F	Y / N		☐	☐	☐	☐	☐	
M / F	Y / N		☐	☐	☐	☐	☐	
Children								
M / F	Y / N		☐	☐	☐	☐	☐	
M / F	Y / N		☐	☐	☐	☐	☐	
M / F	Y / N		☐	☐	☐	☐	☐	

Other disease in your family? (check those that apply)

☐ Asthma	☐ Sickle Cell	☐ Leukemia	☐ Other
☐ Diabetes	☐ Thyroid problem	☐ Bleeding problem	

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other Occupation _____

Do you use tobacco? Yes / No / Quit ☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Snuff How Much? _____

Do you drink alcohol? Yes / No / Quit ☐ Beer ☐ Wine ☐ Mixed Drinks How many drinks per week? _____

Recreational drug use? Yes / No / Quit

Review of Systems

General	Weight Loss / Gain	☐ Yes	☐ No	**Fevers / Chills**	☐ Yes	☐ No
	Loss of Appetite	☐ Yes	☐ No	**Night Sweats**	☐ Yes	☐ No
	Fatigue	☐ Yes	☐ No		☐ Yes	☐ No
Eyes	Glasses or contacts	☐ Yes	☐ No	**Blurry Vision**	☐ Yes	☐ No
	Glaucoma	☐ Yes	☐ No	**Cataracts**	☐ Yes	☐ No
ENT	Hearing difficulty	☐ Yes	☐ No	**Ringing in ears**	☐ Yes	☐ No
	Nosebleeds	☐ Yes	☐ No	**Sinus problems**	☐ Yes	☐ No
	Sore throat / Mouth sores	☐ Yes	☐ No	**Difficulty swallowing**	☐ Yes	☐ No
	Hoarseness / Voice change	☐ Yes	☐ No	**Unusual or metallic taste**	☐ Yes	☐ No
Cardiovasc.	Chest pain / tightness	☐ Yes	☐ No	**Shortness of breath**	☐ Yes	☐ No
	Irregular heartbeat	☐ Yes	☐ No	**Difficulty walking stairs / hill**	☐ Yes	☐ No
	Swelling in hands or feet	☐ Yes	☐ No	**Leg pain or cramps with walking**	☐ Yes	☐ No
Respiratory	Persistent Cough	☐ Yes	☐ No	**Wheezing**	☐ Yes	☐ No
	Blood in sputum	☐	☐	**Exposure to tuberculosis**	☐	☐ No

		Yes	No		Yes	

GI	Nausea / vomiting	☐ Yes	☐ No	**Diarrhea**	☐ Yes	☐ No
	Black or bloody stools	☐ Yes	☐ No	**Constipation**	☐ Yes	☐ No
	Frequent heartburn	☐ Yes	☐ No	**Hemorrhoids**	☐ Yes	☐ No
Urinary	Blood in urine	☐ Yes	☐ No	**Foamy urine**	☐ Yes	☐ No
	Burning with urinating	☐ Yes	☐ No	**Straining to urinate/weak stream**	☐ Yes	☐ No
	Urinate more that once at night	☐ Yes	☐ No	**Kidney stone**	☐ Yes	☐ No
	Frequent kidney infections	☐ Yes	☐ No	**Leaking bladder**	☐ Yes	☐ No
Musculo-Skeletal	Muscle pain or weakness	☐ Yes	☐ No	**Bone / Joint pain**	☐ Yes	☐ No
	Arthritis	☐ Yes	☐ No	**Gout**	☐ Yes	☐ No
Skin	Rashes / Sores	☐ Yes	☐ No	**Abnormal moles / pigment**	☐ Yes	☐ No
Neurologic	Seizures	☐ Yes	☐ No	**Numbness**	☐ Yes	☐ No
	Headaches	☐ Yes	☐ No	**Dizziness/vertigo/balance prob.**	☐ Yes	☐ No
Psychiatric	Depression	☐ Yes	☐ No	**Trouble sleeping**	☐ Yes	☐ No
	Suicidal thoughts	☐ Yes	☐ No	**Mood disorders**	☐ Yes	☐ No
Hematologic	Easy bruising	☐ Yes	☐ No	**Bleeding/clotting problems**	☐ Yes	☐ No
	Anemia	☐ Yes	☐ No	**Abnormal lymph nodes**	☐ Yes	☐ No
Endocrine	Excess thirst	☐ Yes	☐ No	**Heat or cold intolerance**	☐ Yes	☐ No
	Recent hair loss or growth	☐ Yes	☐ No	**Low blood sugars**	☐ Yes	☐ No
MEN Only	Erection difficulties	☐ Yes	☐ No	**Penile discharge**	☐ Yes	☐ No
	Testicle pain	☐ Yes	☐ No	**Testicle mass**	☐ Yes	☐ No
WOMEN Only	Abnormal PAP	☐ Yes	☐ No	**Vaginal discharge**	☐ Yes	☐ No
	Breast lump/mass/discharge	☐ Yes	☐ No	**Hot flashes**	☐ Yes	☐ No