HEALTH HISTORY

Patient Name: _____AGE:_____ DOB: _____ Date: ___/___/____

Primary Physician_____ Pharmacy_____

Reason for Today's Visit _____

Have you ever had the following: Please circle.

Kidney Disease	Heart Disease	Asthma	Epilepsy/Seizures
Thyroid Disease	High Blood Pressure	COPD	Bleeding Tendency
Diabetes	Stroke	Sleep Apnea	Aids or HIV
Latex Allergy	Hepatitis	Arthritis	

Cancer (type):_____

Date of last Colonoscopy: _____ Date of last Mammogram: _____

Past Surgical History	**When**	**Where**
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: _____

MEDICATIONS: _____

Patient Social History

Marital Status: Single____ Married ___ Separated ___ Divorced ___ Widowed ____

Alcohol Use Never ___ Rarely ___ Moderate ___ Daily ___

Tobacco Use Never ___ Current (packs per day) _____ Previous ___ Chew/Snuff ___

Drug Use Never ___ Current (Type & frequency)_____

Family Medical History

	Age	Diseases	If Deceased, cause of death
Father	____	_____	_____
Mother	____	_____	_____
Siblings:	____	_____	_____
	____	_____	_____
Children	____	_____	_____
	____	_____	_____

PATIENT NAME: _____ **DOB:**_____

Please circle any that apply:

Fever Chills Weakness Loss of Appetite

Blurred vision Double Vision Eye Pain

Ear pain Hearing Loss Ringing in Ears Nose Bleeds Throat Pain
Hoarseness Difficulty Swallowing

Neck Pain Neck Swelling

Cough Shortness of Breath Coughing Blood Wheezing

Chest Pain Palpitations Murmur Leg Swelling

Abdomen Distention Abdomen Pain Constipation Diarrhea
Nausea Vomiting Blood in Stool

Blood in Urine Burning during urination Urinary Problems
Discharge Pelvic Pain Incontinence

Joint Pain Back Pain Joint Swelling Muscle Cramps
Muscle Pain Varicose Veins

Ulcerations Wounds Rash Jaundice

Headache Seizures Dizziness Numbness Paralysis Weakness

Anxiety Depression Suicidal

Cold Intolerance Heat Intolerance Weight Loss Weight Gain

Bleeding Bruising Lymphadenopathy Blood Clots

Allergies Hives Itching

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect medical information can be dangerous to my health and 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**