HEALTH HISTORY AND DATABASE

Please complete both sides of this form completely. All Information is confidential and is reviewed by your physician.

Name _____

Today's Date _____ **Birth Date** _____ **Age** _____

What is the reason for your visit?

Place a ✓ next to conditions you have now or have had in the past

☐ AIDS or HIV positive	☐ Eczema/psoriasis	☐ High blood pressure	☐ Pneumonia
☐ Alcohol or drug addiction	☐ Emphysema	☐ Jaundice	☐ Polio
☐ Anemia	☐ Epilepsy	☐ Joint injury	☐ Prostate disorder
☐ Anorexia	☐ Gallbladder problem	☐ Kidney disease	☐ Psychiatric disorder
☐ Appendicitis	☐ Glaucoma	☐ Kidney stones	☐ Rheumatic fever
☐ Arthritis	☐ Goiter	☐ Liver disease	☐ Scarlet fever
☐ Asthma	☐ Gout	☐ Measles	☐ Seizures
☐ Bone fracture	☐ Hay fever/allergies	☐ Migraine headaches	☐ Severe allergic reaction
☐ Breast disorder	☐ Heart murmur	☐ Miscarriage	☐ Stroke
☐ Bronchitis	☐ Heart problem	☐ Multiple sclerosis	☐ Suicide attempt
☐ Bulimia	☐ Heart attack	☐ Mumps	☐ Thyroid disorder
☐ Cataracts	☐ Heartburn	☐ Osteoporosis/thin bones	☐ Tuberculosis
☐ Cancer	☐ Hemorrhoids	☐ Pacemaker	☐ Tumors
☐ Chicken pox	☐ Hepatitis	☐ Phobias	☐ Ulcers
☐ Depression	☐ Hernia	☐ Phlebitis	☐ Urinary infections
☐ Diabetes	☐ Herpes	☐ Pleurisy	☐ Varicose veins
☐ Diverticulosis	☐ High cholesterol		☐ Venereal disease

List Hospital Admissions, Operations, Illnesses, and Serious Injuries (not including pregnancies)	**Year**	**Illness or operation**	**Year**	**Illness or operation**

List all medications you are now taking including over the counter medications, supplements and vitamins		**Medication allergies**	**Vaccine**	**Year of last**	**Test/exam**	**Year of last**
			Tetanus		Tuberculosis	
			Flu shot		Cholesterol	
			Pneumonia		Eye Exam	
			Date of last complete physical?			

Females only-please complete

Number of pregnancies	Birth control method
Number of live births	Date of last menstrual period
Number of abortions	Date of last pap smear
Number of miscarriages	Date of last mammogram

Family History **If any blood relative has suffered any of the following, please indicate below with a ✓.**

	Mother	**Father**	**Sibling**	**Child**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Alcohol abuse	☐	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Bleeds easily	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Drug abuse	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐
Kidney problems	☐	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid Problem	☐	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐

Symptoms: Mark (c) for current problems or check (✓) for past problems

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Loss of appetite (recent)
- ☐ Sweats
- ☐ Weight gain
- ☐ Weight loss

Eyes
- ☐ Failed vision
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye infections frequent
- ☐ Eye pain

ENMT
- ☐ Bleeding gums
- ☐ Decreased hearing
- ☐ Difficulty swallowing
- ☐ Ear infections
- ☐ Ear pain
- ☐ Hoarseness
- ☐ Painful swallowing
- ☐ Recurrent nose bleeds
- ☐ Ringing in ear
- ☐ Sinus trouble
- ☐ Sore throats

CV
- ☐ Chest pain
- ☐ Dizzy spells
- ☐ Fainting spells
- ☐ Irregular pulse/palpitations
- ☐ Leg pain when walking
- ☐ Rapid heartbeat
- ☐ Swollen ankles

Respiratory
- ☐ Wheezing
- ☐ Bronchitis or chronic cough
- ☐ Shortness of breath

Gastro-intestinal
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Bloody or tarry stools
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Persistent nausea/vomiting
- ☐ Rectal bleeding
- ☐ Vomiting blood

Allergy/Immunology
- ☐ Hives

GU
- ☐ Decrease in urine force/flow
- ☐ Loss of bladder control
- ☐ Urethral discharge
- ☐ Venereal disease

Males only
- ☐ Discharge from penis
- ☐ Erectile difficulties
- ☐ Lump in testicles
- ☐ Sore on genitals

Females only
- ☐ Abnormal pap smear
- ☐ Irregular cycle
- ☐ Menstrual flow is heavy
- ☐ Painful intercourse
- ☐ Painful menstruation
- ☐ Vaginal discharge

Skeleton and Muscles
- ☐ Back pain
- ☐ Cold feet
- ☐ Muscle weakness
- ☐ Pain, Location:

Skin
- ☐ Change in moles
- ☐ Easy bruising
- ☐ Lump in breast or nipple
- ☐ Nipple discharge
- ☐ Non-healing sore
- ☐ Skin cancer or tumors

Neurological
- ☐ Dizzy or room spins
- ☐ Frequent or severe headache
- ☐ Memory loss
- ☐ Numbness/tingling sensations
- ☐ Tremor/hands shaking

Psychiatric
- ☐ Excessive moodiness
- ☐ Mental Illness
- ☐ Nervousness
- ☐ Sleeping difficulty

Endocrine
- ☐ Excessive hunger/thirst
- ☐ Flushing/menopause
- ☐ Frequently cold
- ☐ Frequently hot
- ☐ Hot Flashes

Hematologic/Lymphatic
- ☐ Swelling/lump in armpits
- ☐ Swelling/lump in groin
- ☐ Swelling/lump in neck

Health Risk Assessment (Please describe any that apply)

Tobacco use	Caffeinated beverages	
Alcohol use	Occupation	
Drug use	Exposure to hazardous substances	
Intravenous drug use	Regular exercise	
Do you have any special needs related to cultural beliefs? (i.e. diet, blood transfusions, religious practices- if so describe)	☐ Yes ☐ No	
Do you have any special educational or communication needs?	☐ Yes ☐ No	
Do you have any special physical development or learning disabilities?	☐ Yes ☐ No	
Any food allergies or intolerances?	☐ Yes ☐ No	
Please check **(✓)** next to items you have in your household.	☐ Smoke detector ☐ Firearms or weapon	☐ Carbon monoxide detector ☐ Fire extinguisher
Do you routinely wear your seatbelt?	☐ Yes ☐ No	
Do you wear a helmet while biking or rollerblading?	☐ Yes ☐ No	
Have you ever been a victim of domestic violence abuse or sexual assault?	☐ Yes ☐ No	
Are you sexually active?	☐ Yes ☐ No	
Do you practice safe sex?	☐ Yes ☐ No	
Number of partners: 1) last year, 2) lifetime?		
Information completed by patient's family member or significant other?	☐ Yes ☐ No	
Previous physician and or office location with your medical records?		
Is English your primary language? If not, what is?	☐ Yes ☐ No	

The information above is accurate and complete to the best of my knowledge.

Signature: Date

Reviewed: Date