

# HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Date: \_\_\_\_\_  
 Patient # \_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

**History of present illness:**

**Location:** \_\_\_\_\_  
 (Where is the pain/problem?)

**Quality** \_\_\_\_\_  
 (Example: normal versus abnormal color, activity, etc.)

**Severity** \_\_\_\_\_  
 (How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

**Duration** \_\_\_\_\_  
 (How long have you had this pain/problem?, or, When did it start?)

**Timing** \_\_\_\_\_  
 (Does the pain/problem occur at a specific time?)

**Context** \_\_\_\_\_  
 (Where were you at the onset of this pain/problem?)

**Associated signs/symptoms** \_\_\_\_\_  
 \_\_\_\_\_  
 (What other associated problems have you been having?)

**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 "no" or "yes", leave blank if uncertain)

Measles .....	no	yes	Anemia .....	no	yes	Back trouble .....	no	yes	Hepatitis .....	no	yes
Mumps .....	no	yes	Bladder Infections .....	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	Hemorrhoids .....	no	yes	Thyroid Disease .....	no	yes
Scarlet Fever .....	no	yes	Tuberculosis .....	no	yes	Date of last chest x-ray .....			Bleeding Tendency .....	no	yes
Diphtheria .....	no	yes	Diabetes .....	no	yes	Asthma .....	no	yes	Any other disease .....	no	yes
Smallpox .....	no	yes	Cancer .....	no	yes	Hives or Eczema .....	no	yes	(please list):		
Pneumonia .....	no	yes	Polio .....	no	yes	AIDS or HIV+ .....	no	yes	_____		
Rheumatic Fever .....	no	yes	Glaucoma .....	no	yes	Infectious Mono .....	no	yes	_____		
Heart Disease .....	no	yes	Hernia .....	no	yes	Bronchitis .....	no	yes	_____		
Arthritis .....	no	yes	Blood or Plasma Transfusions .....	no	yes	Mitral Valve Prolapse .....	no	yes	_____		
Venereal Disease .....	no	yes				Stroke .....	no	yes	_____		

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

**Medications:** (Include nonprescription) \_\_\_\_\_  
 \_\_\_\_\_

**Patient social history:**

Marital status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_  
 Use of alcohol: Never: \_\_\_\_\_ Rarely: \_\_\_\_\_ Moderate: \_\_\_\_\_ Daily: \_\_\_\_\_  
 Use of tobacco: Never: \_\_\_\_\_ Previously, but quit: \_\_\_\_\_ Current packs / day: \_\_\_\_\_  
 Use of drugs: Never: \_\_\_\_\_ Type/Frequency: \_\_\_\_\_  
 Excessive exposure at home or work to: Fumes: \_\_\_\_\_ Dust: \_\_\_\_\_ Solvents: \_\_\_\_\_ Air-borne Particles: \_\_\_\_\_ Noise: \_\_\_\_\_

**Family medical history:**

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

**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  
 Headaches . . . . . No Yes

**Eyes**

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

**Ears/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

**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

**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  
 Change in bowel movements . . . No Yes  
 Nausea or vomiting . . . . . No Yes  
 Frequent diarrhea . . . . . No Yes  
 Painful bowel movements  
 or constipation . . . . . No Yes  
 Rectal bleeding or blood in stool No Yes  
 Abdominal pain . . . . . No Yes

**Genitourinary**

Frequent urination . . . . . No Yes  
 Burning or painful urination . . . No Yes  
 Blood in urine . . . . . No Yes  
 Change in force of strain  
 when urinating . . . . . No Yes  
 Incontinence or dribbling . . . . . No Yes  
 Kidney stones . . . . . No Yes  
 Sexual difficulty . . . . . No Yes  
 Male - testicle pain . . . . . No Yes  
 Female - pain with periods . . . . . No Yes  
 Female - irregular periods . . . . . No Yes  
 Female - vaginal discharge . . . . . No Yes  
 Female - # of pregnancies . . . . . \_\_\_\_\_  
 Female - # of miscarriages . . . . . \_\_\_\_\_  
 Female - date of last pap smear \_\_\_\_\_

**Musculoskeletal**

Joint pain . . . . . No Yes  
 Joint stiffness or swelling . . . . . No Yes  
 Weakness of muscles or joints . . No Yes  
 Muscle pain or cramps . . . . . No Yes  
 Back pain . . . . . No Yes  
 Cold extremities . . . . . No Yes  
 Difficulty in walking . . . . . No Yes

**Integumentary (skin, breast)**

Rash or itching . . . . . No Yes  
 Change in skin color . . . . . No Yes  
 Change in hair or nails . . . . . No Yes  
 Varicose veins . . . . . No Yes  
 Breast pain . . . . . No Yes  
 Breast lump . . . . . No Yes  
 Breast discharge . . . . . 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  
 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**

Glandular or hormone problem. No Yes  
 Excessive thirst or urination . . . No Yes  
 Heat or cold intolerance . . . . . No Yes  
 Skin becoming dryer . . . . . No Yes  
 Change in hat or glove size . . . . No Yes

**Hematologic/Lymphatic**

Slow to heal after cuts . . . . . No Yes  
 Bleeding or bruising tendency . . No Yes  
 Anemia . . . . . No Yes  
 Phlebitis . . . . . No Yes  
 Past transfusion . . . . . No Yes  
 Enlarged glands . . . . . No Yes

**Allergic/Immunologic**

History of skin reaction or other adverse reaction to:  
 Penicillin or other antibiotics . No Yes  
 Morphine, Demerol,  
 or other narcotics . . . . . No Yes  
 Novocain or other anesthetics No Yes  
 Aspirin or other pain remedies No Yes  
 Tetanus antitoxin  
 or other serums . . . . . No Yes  
 Iodine, Merthiolate or  
 other antiseptic . . . . . No Yes  
 Other drugs/medications: \_\_\_\_\_

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

\_\_\_\_\_  
 Date

**Doctor's Review**

\_\_\_\_\_  
 Signature of Doctor

\_\_\_\_\_  
 Date