

## HEALTH HISTORY (Confidential)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

What is your reason for this visit? \_\_\_\_\_

**SYMPTOMS** Check symptoms you currently have or have had in the past year.

|   |   |  |   |
|---|---|--|---|
| <p><b>GENERAL</b></p> <p>Chills<br/>Depression<br/>Dizziness<br/>Fainting<br/>Fever<br/>Forgetfulness<br/>Headache<br/>Loss of sleep<br/>Loss of weight<br/>Nervousness<br/>Numbness<br/>Sweats</p> <p><b>MUSCLE/JOINT/BONE</b></p> <p>Pain, weakness, numbness in:<br/>Arms            Hips<br/>Back            Legs<br/>Feet            Neck<br/>Hands           Shoulders<br/>Bone Density Year: _____</p> <p><b>GENITO-URINARY</b></p> <p>Blood in urine<br/>Frequent urination<br/>Lack of bladder control<br/>Painful urination</p> | <p><b>GASTROINTESTINAL</b></p> <p>Appetite poor<br/>Bloating<br/>Bowel changes<br/>Constipation<br/>Diarrhea<br/>Excessive hunger<br/>Excessive thirst<br/>Gas<br/>Hemorrhoids<br/>Indigestion<br/>Nausea<br/>Rectal bleeding<br/>Stomach pain<br/>Vomiting<br/>Vomiting blood<br/>Colonoscopy Year: _____</p> <p><b>CARDIOVASCULAR</b></p> <p>Chest Pain<br/>High blood pressure<br/>Irregular heart beat<br/>Low blood pressure<br/>Poor circulation<br/>Rapid heart beat<br/>Swelling of ankles<br/>Varicose veins</p> | <p><b>EYE, EAR, NOSE, THROAT</b></p> <p>Bleeding gums<br/>Blurred vision<br/>Crossed eyes<br/>Difficulty swallowing<br/>Double vision<br/>Earache<br/>Ear discharge<br/>Hay fever<br/>Hoarseness<br/>Loss of hearing<br/>Nosebleeds<br/>Persistent cough<br/>Ringing in ears<br/>Sinus problems<br/>Vision - Flashes<br/>Vision - Halos</p> <p><b>SKIN</b></p> <p>Bruise easily<br/>Hives<br/>Itching<br/>Changes in moles<br/>Rash<br/>Scars<br/>Sore that won't heal</p> | <p><b>MEN ONLY</b></p> <p>Breast lump<br/>Erection difficulties<br/>Lump in testicles<br/>Penis discharge<br/>Sore on penis<br/>Other _____</p> <p><b>WOMEN ONLY</b></p> <p>Abnormal Pap smear<br/>Bleeding between periods<br/>Breast lump<br/>Extreme menstrual pain<br/>Hot flashes<br/>Nipple discharge<br/>Painful intercourse<br/>Vaginal discharge<br/>Other _____</p> <p>Date of last menstrual period _____<br/>Date of last Pap smear _____<br/>Have you had a Mammogram? _____<br/>Are you pregnant? _____<br/># of children _____</p> |
|---|---|--|---|

**CONDITIONS** Check conditions you currently have or have had in the past.

|                    |                     |                    |                    |
|--------------------|---------------------|--------------------|--------------------|
| AIDS               | Chemical Dependency | High Cholesterol   | Prostate Problem   |
| Alcoholism         | Chicken Pox         | HIV Positive       | Psychiatric Care   |
| Anemia             | Diabetes            | Kidney Disease     | Rheumatic Fever    |
| Anorexia           | Emphysema           | Liver Disease      | Scarlet Fever      |
| Appendicitis       | Epilepsy            | Measles            | Stroke             |
| Arthritis          | Glaucoma            | Migraine Headaches | Suicide Attempt    |
| Asthma             | Goiter              | Miscarriage        | Thyroid Problems   |
| Bleeding Disorders | Gonorrhea           | Mononucleosis      | Tonsillitis        |
| Breast lump        | Gout                | Multiple Sclerosis | Tuberculosis       |
| Bronchitis         | Heart Disease       | Mumps              | Typhoid Fever      |
| Bulimia            | Hepatitis           | Pacemaker          | Ulcers             |
| Cancer             | Hernia              | Pneumonia          | Vaginal Infections |
| Cataracts          | Herpes              | Polio              | Venereal Disease   |

**MEDICATIONS:** List medications you are currently taking. Include Dose/Taking for/Date Began.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you need more space for listing medications, please use the back of this page.

Pharmacy Name: \_\_\_\_\_ Number: 713.527.0000  
(If you use mail order include company but provide a local pharmacy as well)

**FAMILY HISTORY** — Fill in health information about your family Check if your blood relatives had any of the following

| Relation | Age | State of Health | Age at Death | Cause of Death | Disease                | Relationship to You |
|----------|-----|-----------------|--------------|----------------|------------------------|---------------------|
| Father   |     |                 |              |                | Arthritis, Gout        |                     |
| Mother   |     |                 |              |                | Asthma, Hay Fever      |                     |
| Brothers |     |                 |              |                | Cancer                 |                     |
|          |     |                 |              |                | Chemical Dependency    |                     |
|          |     |                 |              |                | Diabetes               |                     |
|          |     |                 |              |                | Heart Disease, Strokes |                     |
| Sisters  |     |                 |              |                | High Blood Pressure    |                     |
|          |     |                 |              |                | Kidney Disease         |                     |
|          |     |                 |              |                | Tuberculosis           |                     |
|          |     |                 |              |                | Other                  |                     |

**HOSPITALIZATIONS**

**PREGNANCY HISTORY**

| Year | Hospital | Reason for Hospitalization and Outcome | Year of Birth | Sex of Baby | Complications if any |
|------|----------|--|---------------|-------------|----------------------|
|      |          |  |               |             |                      |
|      |          |  |               |             |                      |
|      |          |  |               |             |                      |
|      |          |  |               |             |                      |

Have you ever had a blood transfusion? Yes No  
If yes, please give approximate dates

**HEALTH HABITS**

Check which substance you use and amount

| Serious Illness/Injuries | Date | Outcome | Caffeine |
|--------------------------|------|---------|----------|
|                          |      |         | Tobacco  |
|                          |      |         | Drugs    |
|                          |      |         | Other    |

**OCCUPATION CONCERNS**

Check if your work exposes you to the following:

|  |  |  |                      |
|--|--|--|----------------------|
|  |  |  | Stress               |
|  |  |  | Hazardous Substances |
|  |  |  | Heavy Lifting        |
|  |  |  | Other                |
|  |  |  | Your Occupation:     |

Are you currently disabled? Reason: \_\_\_\_\_  
When occurred? \_\_\_\_\_

**ALLERGIES:** List medications or substance

\_\_\_\_\_

\_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I have made in the completion of this form.

Signature: \_\_\_\_\_ Relation to patient: \_\_\_\_\_