Patient Health History Form

As you review the following list, please check any problems or conditions, that you are experiencir have experienced. If you do not have any of the problems listed in the section please check none.

General Health
- ❑ Good general health
- ❑ Recent weight change
- ❑ Loss of appetite
- ❑ Fatigue
- ❑ Fever/chills

Allergy
- ❑ Drug allergies
- ❑ Food allergies
- ❑ Hay fever
- ❑ Other: _____
- ❑ None

Ears, Nose, Mouth, Throat
- ❑ Difficulty swallowing
- ❑ Earaches
- ❑ Loss of hearing/deafness
- ❑ Loss of smell
- ❑ Loss of taste
- ❑ Painful chewing
- ❑ Ringing in ears
- ❑ Sinus infection
- ❑ Sores in mouth
- ❑ None
- ❑ Other: _____

Eyes
- ❑ Blind spots
- ❑ Blurred vision
- ❑ Double vision
- ❑ Loss of vision
- ❑ Glaucoma
- ❑ Injury
- ❑ Pain
- ❑ Other: _____
- ❑ None

Gastrointestinal
- ❑ Blood in stools
- ❑ Increasing constipation
- ❑ Nausea
- ❑ Painful bowel movements
- ❑ Persistent diarrhea
- ❑ Stomach or abdominal pain
- ❑ Ulcer
- ❑ Vomiting
- ❑ Other: _____
- ❑ None

Genitourinary
- ❑ Blood in urine
- ❑ Female: irregular periods
- ❑ Female: #pregnancies_____ #miscarriages_____
- ❑ Female: vaginal discharge
- ❑ Kidney stones
- ❑ Male: prostate disease
- ❑ Male: testicle pain
- ❑ Painful or burning urination
- ❑ Sexual difficulty
- ❑ Sexually transmitted disease
- ❑ Urgency with urination
- ❑ Urine retention/ incontinence
- ❑ Other: _____
- ❑ None

Heart and Lungs
- ❑ Pain in chest
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heart beat
- ❑ Other: _____
- ❑ None

Muscles/Joints/Bones
- ❑ Back pain
- ❑ Difficulty walking
- ❑ Joint pain
- ❑ Joint stiffness or swelling
- ❑ Muscle pain or tenderness
- ❑ Neck pain
- ❑ None

Neurological
- ❑ Balance trouble
- ❑ Black outs/loss of consciousness
- ❑ Difficulty speaking
- ❑ Difficulty walking
- ❑ Facial drooping
- ❑ Headaches
- ❑ Injury to the brain or spine
- ❑ Light-headed or dizziness
- ❑ Memory loss
- ❑ Mental Confusion
- ❑ Migraines
- ❑ Mini stroke
- ❑ Neuropathy
- ❑ Numbness or tingling
- ❑ Paralysis
- ❑ Stroke
- ❑ Tremors
- ❑ Weakness
- ❑ Other: _____
- ❑ None

Are you? ❑ right handed ❑ left handed ❑ Both

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Eating disorder
- ❑ Other: _____
- ❑ None

Pulmonary
- ❑ Asthma
- ❑ Blood in cough
- ❑ Cancer
- ❑ Chronic or frequent cough
- ❑ Emphysema
- ❑ Pneumonia
- ❑ Shortness of breath
- ❑ Other: _____
- ❑ None

Skin
- ❑ Rash or itching
- ❑ Sun sensitivity
- ❑ Hair loss
- ❑ Color changes
- ❑ Other: _____
- ❑ None

Sleep
- ❑ Snoring
- ❑ Sleepwalking
- ❑ Nightmares

Do you sleep well? ❑Yes ❑No
Do you feel rested when you wake? ❑Yes ❑No
Do you fall asleep during the day? ❑Yes ❑No

Patient Health History Form

Name: _____ **Date:** _____
SSN: _____ **DOB:** _____

Chief Complaint: What is the reason for your visit today (please describe problem in detail): _____

_____

_____

_____

Past Medical History: Please check all that apply to you:

- ❑ Arthritis
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Epilepsy/seizures
- ❑ Heart problems
- ❑ Heart surgery
- ❑ High blood pressure
- ❑ Psychiatric disease
- ❑ Stroke
- ❑ Thyroid
- ❑ None

Previous Surgeries: Please list past surgeries with approximate date: _____

_____

_____

_____

Serious Injury: Please describe any serious injuries you have had: _____

_____

Medications: Please list any medications you are taking with dose and frequency:

Drug	***Dose/Frequency***

Allergies: please list any allergies that you have _____

_____

Do you drink alcohol? ❑Yes ❑No If yes, how much/week? _____
Do you smoke? ❑Yes ❑No If yes, how many cigarettes/day? _____
Do you consume caffeine? ❑Yes ❑No If yes, how many cups/week? _____
Do you use recreation drugs? ❑Yes ❑No If yes, what type and frequency? _____
Are you on a special diet? ❑Yes ❑No If yes, please describe? _____

Family History: Do you know of any blood relative who has or had:

- ❑ Asthma
- ❑ Aneurysm
- ❑ Brain Tumor
- ❑ Cancer, Type:
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ Headaches
- ❑ Heart Problems
- ❑ High blood pressure
- ❑ Kidney disease
- ❑ Lung Disease
- ❑ Migraine
- ❑ Multiple Sclerosis
- ❑ Psychiatric Disease
- ❑ Stroke
- ❑ Thyroid
- ❑ None

Comments: