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PATIENT HEALTH HISTORY FORM

Date: _____/_____/_____

NAME: _____ **Birthdate:** _____/_____/_____
Last First M. I.

Age:_____ **Sex:** ❑ **F** ❑ **M**

Main reason for the visit:

Describe briefly your present symptoms:

List current health problems for which you are being treated:

Major Hospitalizations (include when, & for what reason):

Do you experience any of these general symptoms EVERY DAY?

❑ Debilitating fatigue	❑ Headaches	❑ Constipation
❑ Depression	❑ Dizziness	❑ Fecal incontinence
❑ Disinterest in sex	❑ Insomnia	❑ Urinary Incontinence
❑ Disinterest in eating	❑ Nausea	❑ Low grade fever
❑ Shortness of breath	❑ Vomiting	❑ Chronic pain/inflammation
❑ Panic attacks	❑ Diarrhea	❑ Bleeding
❑ Discharge	❑ Itching/rash	

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug

Laboratory procedures (e.g., stool analysis, blood and urine chemistries, hair analysis):

Outcome:

Circle the level of stress you are experiencing on scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems:

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right your weight today:

Have you had an unintentional weight loss or gain of 10 pounds or more in the last 3 months:

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman)?

What are your current health goals:

HEALTH HABITS

❑ Tobacco:
Cigarettes: #/day_____
Cigars: #/day_____

❑ Alcohol:
Liquor:_____ Wine:_____
Beer:_____

❑ Caffeine:
Coffee:_____
Tea:_____
Other sources:_____

❑ Water:
Glasses: #/day____

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) _____
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems
❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones
❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS

Other medical conditions (please list):

FAMILY HEALTH HISTORY

(Parents and Siblings)

❑ Arthritis
❑ Asthma
❑ Alcoholism
❑ Alzheimer's disease
❑ Cancer (type)_____
❑ Depression
❑ Diabetes
❑ Other
❑ Drug addiction
❑ Eating disorder
❑ Genetic disorder
❑ Glaucoma
❑ Heart disease
❑ Infertility
❑ Learning disabilities
❑ Mental Illness
❑ Migraine headaches
❑ Neurological disorders
❑ Obesity
❑ Osteoporosis
❑ Stroke
❑ Suicide

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SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:
Pregnancies:
Miscarriages:
Abortions:
Have you reached menopause? Y / N At what age?
Do you have regular periods? Y / N


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