

Patient Name: _____
(Last, First, Middle Initial)

Date of Birth: _____

Date: _____

COMPREHENSIVE HEALTH HISTORY

HAVE YOU EVER HAD

ILLNESSES:

- Measles
- German Measles
- Mumps
- Chicken Pox
- Whooping Cough
- Scarlet Fever or Scarlatina
- Diphtheria
- Smallpox
- Hives or Eczema
- Frequent Infections or Boils
- Migraine Headaches
- Thyroid Disease
- High or Low Blood Pressure
- Heart Attack
- Rheumatic Fever
- Lung Disease
- Tuberculosis
- Pneumonia
- Asthma or Hay Fever
- Breast Disease
- Gallbladder Disease

- Colitis or other bowel disease
- Hemorrhoids or any rectal disease
- Liver Disease
- Kidney Disease
- Bladder Disease
- Sexually Transmitted Disease
- Prostate Disease
- Nerve Pain
- Polio
- Meningitis
- Epilepsy
- Nervous Breakdown / Depression
- Any Bone or Joint Disease
- Back Problems
- Anemia
- Blood Clots
- Diabetes
- AIDS / HIV
- Cancer
- Food, Chemical or Drug Poisoning
- Any Other Disease

INJURIES:

- Broken or cracked bones
- Sprains
- Lacerations
- Dislocations
- Concussion or head injury
- Ever been knocked unconscious

TRANSFUSIONS:

- Blood or plasma transfusion

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR

- Frequent or severe headaches
- Fainting spells
- Dizziness with change of position
- Unconscious spells
- Blurred vision
- Spots before eyes
- Infected eyes
- Pain behind eyes
- Any change in vision
- Do you wear glasses / contacts?
 Last check up
- Ear aches
- Discharge from ears
- Ringing in ears
- Decrease in hearing
- Recurrent nose bleeds
- Recurrent head colds
- Sinus trouble
- Strange persistent odors
- Strange taste or loss of taste
- Persistent hoarseness
- Difficulty swallowing
- Recurrent sores in mouth
- Soreness or bleeding of gums with brushing
- Growth in neck or throat
- Enlarged glands
- Chest pain / angina
- Palpitations or fluttering of heart
- Purple lips or fingers
- Easy bruising
- Swelling of hands, feet or ankles
 At what time of day
- Enlarged veins in legs
- Leg cramps on walking or at night time
- Chronic or frequent cough
- Chronic or frequent cough when lying down

- Coughing up blood
- Shortness of breath on:
 Walking several blocks
 One flight of stairs
 When lying down
- Wake up at night short of breath
- How many bed pillows do you use?
- Appetite - Good Fair Poor
- Recurrent stomach pain
- Abdominal cramping
- Belching or heartburn
 Relieved by food or medication
- Avoid any foods
 What kinds
- Avoid any spices
 What kinds
- Nausea or vomiting
- Vomited blood
- Black stool or blood in stool
- Rectal pain with bowel movement
- Change in size, shape or texture of bowel movement
 Describe
- How many times per day do you urinate
- Urinate more than before
- Urinate less than before
- Do you get up at night to urinate
 How many times
- Any blood in urine
- Pain with urination
- Difficulty in starting urination
- Full feeling of bladder, but only small amount of urine
- Loss of urine on coughing, sneezing or laughing
- Discharge from penis/lesions/rash
- Back aches
- Joint pains / swelling or joints
- Redness or heat of any joint

- Muscle spasms
- Tingling or weakness of hands or feet
- Loss or change in sensation of hands or feet
- Trembling of any extremity
- Tiredness without apparent reason
- Inability to stand heat / cold
- Hot flashes
- Change in hair texture
- Change in skin texture
- Any skin rash
- Brittleness of nails
- Sexual activity satisfactory?

WOMEN ONLY - MENSTRUAL HISTORY

- Age at onset
- Regular? Yes No Varies
Cycle _____ days (from start to finish)
Flow: Heavy Medium Light
- Number of pads used per period
- Any clots passed
- Pains or cramps
- Date of last period
- Date of last pelvic exam
- Date of last Pap Test
Results: Normal Abnormal
- Any abnormal discharge from vagina
- Any itching of vaginal area
- Contraception: Type _____
- Pregnancies:
How many children born alive _____
How many stillbirths _____
How many miscarriages / abortions _____
Any complications with pregnancy _____

PERSONAL HISTORY

PAST MEDICAL HISTORY

MEDICATION	PRESENT MEDICATIONS / HERBS / Over The Counter: PLEASE LIST	DO YOU HAVE ANY MEDICATION/FOOD ALLERGIES <input type="checkbox"/> Yes <input type="checkbox"/> No

MAJOR MEDICAL	MAJOR HOSPITALIZATIONS / SURGERIES / PROCEDURES: YOUR MOST RECENT HOSPITALIZATIONS (DO NOT INCLUDE NORMAL PREGNANCIES):		
	YEAR	HOSPITALIZATION / SURGERY	HOSPITAL / CITY AND STATE

SOCIAL HISTORY	HAVE YOU EVER SMOKED?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes	_____ PACKS / DAY	_____ YEARS
	DO YOU DRINK ALCOHOL?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, how much		
	DO YOU USE ILLICIT DRUGS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, type / amount		
	REGULAR EXERCISE?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how much		
	LIVING SITUATION/SIGNIFICANT OTHERS				Phone #
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FAMILY HISTORY		If Living Age Health	If Deceased Age at Death Cause	Has any blood relative ever had: (please circle)	Who:
	Father			Cancer	Yes
	Mother			Tuberculosis	Yes
	Brother or Sister 1.			Diabetes	Yes
	2.			Heart Trouble	Yes
	3.			High Blood Pressure	Yes
	4.			Stroke	Yes
	5.			Epilepsy	Yes
	Husband or Wife			Mental Illness	Yes
	Son or Daughter 1.			Suicide	Yes
2.					
3.					
4.					

IMMUNIZATION	See Immunization Form
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PHYSICIANS	PHYSICIAN	SPECIALTY

OCCUPATION	OCCUPATION	OCCUPATION
	Employer Job Title	Employer Job Title
HazMat Exposure (i.e., chemical, biological, etc):		

X _____ X _____
 PATIENT'S SIGNATURE DATE PROVIDER'S SIGNATURE DATE