PATIENT HEALTH HISTORY FORM

Name: _____ DOB: _____ Today's Date: _____

Allergies: _____

Review of Systems: Please circle YES or NO that apply to you in the last 3 MONTHS.

	Currently		Past		Notes
Constitutional					
Weight Loss (>10lbs)	Yes	No	Yes	No	
Weight Gain (<10lbs)	Yes	No	Yes	No	
Fatigue	Yes	No	Yes	No	
Eyes					
Vision Changes	Yes	No	Yes	No	
Ear/Nose/Throat					
Ringing in Ears	Yes	No	Yes	No	
Recurrent Sinus Problems	Yes	No	Yes	No	
Recurrent Sore Throat	Yes	No	Yes	No	
Cardiovascular/Respiratory					
Muscle weakness	Yes	No	Yes	No	
Chest pain	Yes	No	Yes	No	
Difficult breathing with exercise	Yes	No	Yes	No	
Swelling of legs	Yes	No	Yes	No	
Asthma	Yes	No	Yes	No	
Palpitations of heart, extra or skipped beats or Murmur					
Shortness of Breath	Yes	No	Yes	No	
Chronic Cough	Yes	No	Yes	No	
Gastrointestinal					
Frequent diarrhea	Yes	No	Yes	No	
Bloody Stool	Yes	No	Yes	No	
Nausea/Vomiting	Yes	No	Yes	No	
Constipation (<3 per week)	Yes	No	Yes	No	
Genitourinary					
Blood in urine	Yes	No	Yes	No	
Kidney Infection	Yes	No	Yes	No	
Urgency or Frequency	Yes	No	Yes	No	
Incomplete emptying	Yes	No	Yes	No	
Stress Incontinence	Yes	No	Yes	No	
Bathroom at night (# of times)	Yes	No	Yes	No	
Skin/Breast					
Pain in Breast	Yes	No	Yes	No	
Discharge	Yes	No	Yes	No	
Lumps	Yes	No	Yes	No	
Rash/Discoloration	Yes	No	Yes	No	
Gynecology					
Irregular Periods	Yes	No	Yes	No	
Painful intercourse	Yes	No	Yes	No	
Hot Flashes	Yes	No	Yes	No	
Verereal/STD's	Yes	No	Yes	No	
Neurological					
Dizziness	Yes	No	Yes	No	
Seizures	Yes	No	Yes	No	
Numbness (where)	Yes	No	Yes	No	
Falling Frequently	Yes	No	Yes	No	
Endocrine					
Abnormal thirst	Yes	No	Yes	No	
Allergic/Immunologic					
Allergies	Yes	No	Yes	No	
Drug Allergy	Yes	No	Yes	No	
Hematologic					
Frequent bruises	Yes	No	Yes	No	

Personal Past History: PLEASE CIRCLE ANY THAT APPLY TO **YOU.**

Major Illnesses			**Major Illnesses**		
Diabetes	Yes	No	Cancer	Yes	No
High Blood Pressure	Yes	No	Depression/Anxiety	Yes	No
Stroke	Yes	No	Anemia/Blood Transfusions	Yes	No
Rheumatic Fever	Yes	No	Seizure/Convulsions/Epilepsy	Yes	No
Glaucoma	Yes	No	Bowel Trouble	Yes	No
Hepatitis/Yellow Jaundice	Yes	No	Thyroid Disease	Yes	No

Operations/Hospitalizations (Describe reason for each)

	Date		**Date**

Current Medications (List drug name(s) & dosage(s)

	Dosage(s)		**Dosage(s)**

FAMILY HISTORY: Please circle YES if a FAMILY MEMBER has or had one of these illnesses

Illness	**Family Member/Age**		**Illness**	**Family Member/Age**	
Diabetes	Yes	No	Drinking Problem	Yes	No
Stroke	Yes	No	Breast Cancer	Yes	No
Heart Disease	Yes	No	Colon Cancer	Yes	No
High Blood Pressure	Yes	No	Female Cancer	Yes	No
Depression	Yes	No			

Social History: Personal Habits

Smoking	Yes	No	Packs per day: _____ # of years: _____
Alcohol	Yes	No	Drinks per day: _____ per week: _____
Drug Use			
Regular Exercise			

Personal Profile

Marital Status: Married Single Widowed Divorced

Number of Births: _____ Number of Living Children: _____ Number of Abortions: _____ Number of Miscarriages: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date Reviewed: _____

Annual Review of History:

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____

Date Reviewed: _____ Physician Signature: _____