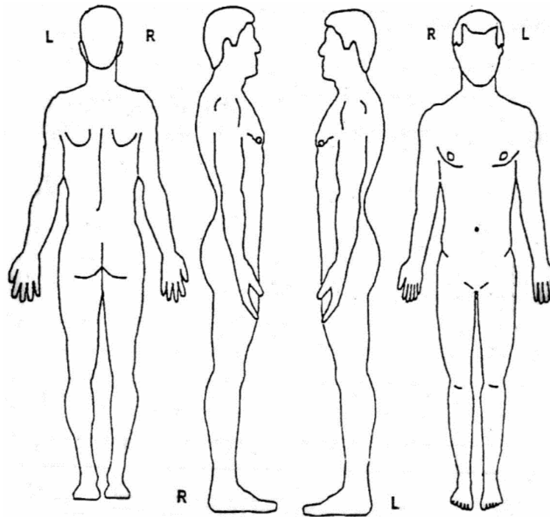
CONFIDENTIAL HEALTH HISTORY

PATIENT NAME: ____ DATE: ______________ CHART #: ______________

INSTRUCTIONS: Please mark the areas on your body where you feel your PAIN. If the pain radiates, draw an arrow from where the pain starts to where it stops. Please extend the arrows as far as the pain travels.



REVIEW OF SYSTEMS

Please check (√) symptoms you currently have.

GENERAL

____Chills
____Depression
____Dizziness
____Fainting
____Fever
____Forgetfulness
____Headache
____Loss of sleep
____Nervousness
____Numbness
____Sweats
____Unexplained Weight Loss

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

____Neck ____Back
____Shoulders ____Hips
____Arms ____Legs
____Hands ____Feet

GENITO-URINARY

____Blood in urine
____Frequent urination
____Lack of bladder control
____Painful urination

GASTROINTESTINAL

____Appetite poor
____Bowel changes
____Constipation
____Diarrhea
____Excessive hunger
____Excessive thirst
____Hemorrhoids
____Indigestion
____Nausea
____Rectal bleeding
____Stomach pain
____Vomiting
____Vomiting blood
____Other

CARDIOVASCULAR

____Chest pain
____High blood pressure
____Irregular heartbeat
____Low blood pressure
____Poor circulation
____Swelling of ankles
____Varicose veins
____Other

EYE, EAR, NOSE, THROAT

____ Blurred vision
____ Difficulty breathing
____ Difficulty swallowing
____Earache
____Ear discharge
____Hay fever
____Hearing loss
____Hoarseness
____Nosebleeds
____Persistent cough
____Ringing in ears
____Sinus problems
____Shortness of breath
____Vision problems
____Wheezing
____Other

SKIN

____Bruise easily
____Hives
____Itching
____Change in moles
____Rash
____Scars
____Sore that won't heal

MEN only

____Breast lump
____Erection difficulties
____Lump in testicles
____Penis discharge
____Sore on penis
____Other

WOMEN only

____Abnormal Pap Smear
____Bleeding between periods
____Breast lump
____Extreme menstrual pain
____Hot flashes
____Nipple discharge
____Painful intercourse
____Vaginal discharge
____Other

Date of last menstrual period ______________________

Date of last Pap Smear: ______________________

Have you had a mammogram? ______________________

Results?____________________

Are you pregnant?____________

TURN PAGE

PAST MEDICAL HISTORY:

Check (√) conditions or illnesses you have or have had in the past.

____AIDS
____Alcoholism
____Anemia
____Anorexia
____Appendicitis
____Arthritis
____Asthma
____Bleeding Disorders
____Breast Lump
____Bronchitis
____Bulimia
____Cancer
____Cataracts
____Chemical Dependency
____Chicken Pox
____Diabetes
____Emphysema
____Epilepsy
____Glaucoma
____Goiter
____Gonorrhea
____Gout
____Heart Disease
____Hepatitis
____Hernia
____Herpes
____High Cholesterol
____HIV Positive
____Kidney Disease
____Liver Disease
____Measles
____Migraine Headaches
____Miscarriage
____Mononucleosis
____Multiple Sclerosis
____Mumps
____Pacemaker
____Pneumonia
____Polio
____Prostate Problem
____Psychiatric Care
____Rheumatic Fever
____Scarlet Fever
____Stroke
____Suicide Attempt
____Thyroid Problems
____Tonsillitis
____Tuberculosis (TB)
____Typhoid Fever
____Ulcers
____Vaginal Infections
____Venereal Disease
___Other

Past Injuries/Accidents (What, when & result):____
____

Past Surgeries/Operations (What, when & result):____
____

Hospitalizations (Reason for hospitalization, date, name of hospital):____
____

Current Medications: ____
____

Allergies: ____

FAMILY HISTORY: Please tell us if there is a history of Cancer, Diabetes, Heart Problems, Stroke, Blood Pressure Problems, Headaches, Neck Pain or Surgeries in your FAMILY.

FAMILY HISTORY	LIVING? MEDICAL PROBLEMS IF ANY:	DECEASED? CAUSE OF DEATH:	AGE
Mother			
Father			
Brother			
Brother			
Sister			
Sister			
Child			
Child			

SOCIAL HISTORY:

Marital Status (circle): Single Married Widowed Divorced Separated **Children:** NO/YES If yes, how many?_____

Current Employment/Occupational History: ____
____

HEALTH HABITS:

Exercise: Type: ____ Freq. ____/week Duration _________Min/Hrs

Check (√) which you use and how much you use:

___Alcoholic Beverages___________________________
___Tobacco____________________________________
___Street Drugs_________________________________
___Caffeine____________________________________

Check (√) if your daily activities or work exposes you to:

___Stress
___Prolonged Sitting/Standing
___Heavy Lifting
___Repetitive Motions
___Hazardous Substances
___Other______________________________________

Physician Signature: _______________________________________ Date: ____________________