



## Health History Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Last Menstrual Period: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year Month Day Year

Referring Physician: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Main reason for today's visit:  
(200 characters maximum)

**REVIEW OF SYMPTOMS:** Have you had or still have any of the following? (Check all that apply.)

**Constitutional**

- Recent fevers/sweats
- Unexplained weight loss/gain
- Unexplained fatigue/weakness
- History of cancers
- None apply

**Eyes**

- Change in vision
- Glaucoma
- Cataract
- Blurry/double vision
- Implants
- None apply

**Ears/Nose/Throat/Mouth**

- Difficulty hearing
- Hay fever/allergies/congestion
- Trouble swallowing
- Voice changes
- None apply

**Breast**

- Breast lumps
- Axillary node lumps
- Nipple discharge
- Skin dimpling
- None apply

**Liver Disease**

- Jaundice
- Hepatitis

**Liver Disease (cont.)**

- Cirrhosis
- None apply

**Respiratory**

- Cough/wheeze
- Coughing up blood
- Emphysema
- Asthma
- Bronchitis
- Sleep apnea
- CPAP/BiPAP
- None apply

**Cardiovascular**

- Chest pains/discomfort
- Short of breath with exertion
- Palpitation
- Angina
- High blood pressure
- Aneurysm
- Mitral valve prolapse
- Defibrillator/Pacemaker
- None apply

**Musculoskeletal**

- Muscle/joint pain
- Recent back pain
- Arthritis
- Osteoporosis
- None apply

**Gastrointestinal**

- Heartburn/reflux
- Blood in stool
- Nausea/vomiting
- Pain in abdomen
- Clay colored stool
- Dark urine
- Diarrhea
- Constipation
- None apply

**Genitourinary**

- Painful/bloody urination
- Nighttime urination
- Discharge: penis or vagina
- Unusual vaginal bleeding
- Concern with sex functions
- Dialysis
- None apply

**Endocrine**

- Cold/heat intolerance
- Increase thirst/appetite
- Thyroid disease
- Parathyroid
- Diabetes
- Pancreas
- Adrenal
- None apply

**Psychiatric**

- Anxiety/stress
- Sleep problems
- Depression
- None apply

**Neurological**

- Headaches
- Memory loss
- Fainting
- Seizures
- Weakness
- None apply

**Blood/Lymphatic**

- Unexplained lumps
- Easy bruising/bleeding
- Blood clot
- Autoimmune
- HIV
- None apply

**Skin**

- Rash
- New or change in mole
- Jaundice
- Cancer
- None apply

*For additional symptoms, please write on last page.*

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**CURRENT MEDICAL PROBLEMS AND DEVICES:** List ALL current medical problems (*CHF, high cholesterol, etc.*) and implantable devices or foreign bodies (*e.g., shrapnel, etc.*)

|    |     |
|----|-----|
| 1) | 6)  |
| 2) | 7)  |
| 3) | 8)  |
| 4) | 9)  |
| 5) | 10) |

**OPERATIONS:** List ALL operations and dates

**Operation / Date**

|    |
|----|
| 1) |
| 2) |
| 3) |
| 4) |

**Operation / Date**

|    |
|----|
| 5) |
| 6) |
| 7) |
| 8) |

**MEDICATIONS:** List ALL current medications (*prescription, aspirin, vitamins, herbal, and over the counter*) and history of immunotherapy or hormone replacements.

**Name of medicine**

**Dose/Route Frequency**

**Name of medicine**

**Dose/Route Frequency**

|    |  |  |
|----|--|--|
| 1) |  |  |
| 2) |  |  |
| 3) |  |  |
| 4) |  |  |
| 5) |  |  |
| 6) |  |  |
| 7) |  |  |
| 8) |  |  |
| 9) |  |  |

|     |  |  |
|-----|--|--|
| 10) |  |  |
| 11) |  |  |
| 12) |  |  |
| 13) |  |  |
| 14) |  |  |
| 15) |  |  |
| 16) |  |  |
| 17) |  |  |
| 18) |  |  |

**ALLERGIES:** List ALL allergies with reactions including medications, food, environmental, or chemical (*latex, tape, contrast dye*).

**Allergy / Reaction**

|    |
|----|
| 1) |
| 2) |
| 3) |

**Allergy / Reaction**

|    |
|----|
| 4) |
| 5) |
| 6) |

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**FAMILY HISTORY:** Has anyone in your family had the following? List relationship (ex. parent, sibling, etc.)

- Heart disease/heart attack \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Cancer \_\_\_\_\_
- Stroke/vascular disease \_\_\_\_\_
- Other \_\_\_\_\_

### SOCIAL HISTORY:

#### Tobacco Use

Cigarettes  Never Quit Date: \_\_\_\_\_  Current Smoker Packs/Day: \_\_\_\_\_ # of Years: \_\_\_\_\_

#### Alcohol Use

Do you drink alcohol?  Yes  No # of Drinks/Week: \_\_\_\_\_

#### Drug Use

Do you use or have you used any recreational drugs?  Yes  No

if Yes, list drug(s) and last date used: \_\_\_\_\_

Have you ever used needles to inject drugs?  Yes  No

### SOCIOECONOMICS:

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Years of Education/Highest Degree: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Divorced

Spouse's/Partner's Name: \_\_\_\_\_

# of Children: \_\_\_\_\_ Ages: \_\_\_\_\_

Who lives at home with you?: \_\_\_\_\_



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**ADDITIONAL NOTES:** Write any additional information or changes below and date.

| Name of medicine | Dose/Route | Frequency | Operation / Date |
|------------------|------------|-----------|------------------|
| 1)               |            |           | 1)               |
| 2)               |            |           | 2)               |
| 3)               |            |           | 3)               |
| 4)               |            |           | 4)               |
| 5)               |            |           | 5)               |
| 6)               |            |           | 6)               |
| 7)               |            |           | 7)               |
| 8)               |            |           | 8)               |
| 9)               |            |           | 9)               |

| Date | Change to be Noted |
|------|--------------------|
|      |                    |
|      |                    |
|      |                    |
|      |                    |
|      |                    |
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|      |                    |

**ADDITIONAL NOTES:**