HEALTH HISTORY
(Confidential)

Name _____ Today's Date_____
First Middle Last

Age_____ Date of Birth_____ Date of last physical examination_____

Reason for Visit: _____

SYMPTOMS Check (√) the symptoms you currently have or have had in the past year.

GENERAL

- □ dizziness
- □ fainting
- □ chills
- □ fever
- □ headache
- □ weight gain
- □ weight loss
- □ nervousness
- □ depression
- □ forgetfulness
- □ clouded thinking
- □ loss of sleep
- □ shortness of breath
- □ cough
- □ low libido (sex drive)

GASTROINTESTINAL

- □ poor appetite
- □ bloating
- □ bowel changes
- □ constipation
- □ diarrhea
- □ excessive hunger
- □ excessive thirst
- □ gas
- □ hemorroids
- □ indigestion
- □ nausea
- □ stomach pain
- □ vomiting
- □ heart burn
- □ rib-side pain

GENITO-URINARY

- □ blood in urine
- □ frequent urination
- □ lack of bladder control
- □ painful urination

EYE, EAR, NOSE, THROAT

- □ blurred vision
- □ double vision
- □ dry eyes
- □ earache
- □ loss of hearing
- □ ringing in ears
- □ nosebleeds
- □ sinus blockage
- □ difficulty swallowing
- □ hoarseness
- □ persistent cough
- □ sinus problems

SKIN

- □ bruise easily
- □ hives
- □ rash
- □ itching
- □ change in moles
- □ scars
- □ acne
- □ sore that won't heal

MUSCLE/JOINT/BONE

pain, weakness, numbness in

- □ arms
- □ back
- □ feet
- □ hands
- □ hips
- □ legs
- □ neck
- □ shoulders

CARDIOVASCULAR

- □ chest pain
- □ high blood pressure
- □ irregular heart beat
- □ low blood pressure
- □ poor circulation
- □ rapid heart beat
- □ swelling of the ankles
- □ varicose veins

CONDITIONS Check (√) the conditions you currently have or have had.

- □ 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
- □ typhoid fever
- □ ulcers
- □ vaginal infections
- □ venereal diseases

Please list all medications you are taking, the duration, and their dosages:

1. _____ Duration: _____ Dosage: _____
2. _____ Duration: _____ Dosage: _____
3. _____ Duration: _____ Dosage: _____
4. _____ Duration: _____ Dosage: _____
5. _____ Duration: _____ Dosage: _____
6. _____ Duration: _____ Dosage: _____

Please list all herbs and supplements you take on a regular basis:
(please include duration and dosage)

1. _____ Duration: _____ Dosage: _____
2. _____ Duration: _____ Dosage: _____
3. _____ Duration: _____ Dosage: _____
4. _____ Duration: _____ Dosage: _____
5. _____ Duration: _____ Dosage: _____
6. _____ Duration: _____ Dosage: _____

Please list allergies to medications, substances, or food:

_____

_____

_____

Please list all health care practitioners:

Primary Care, M.D.: _____ Tel.: _____

Gynecologist.: _____ Tel.: _____

Other (medical doctors, osteopaths, chiropractor, psychotherapy, massage, etc.:
_____ Tel.: _____

_____ Tel.: _____

_____ Tel.: _____

_____ Tel.: _____

HOSPITALIZATIONS		
Year	Hospital	Reason for Hospitalization and Outcome

SERIOUS ILLNESS/INJURIES	Date	Outcome

FAMILY HISTORY			
Relation	Age	Current health problems	Past health problems
Mother			
Father			
Brothers			
Sisters			
Maternal Grandmother			
Maternal Grandfather			
Fraternal Grandmother			
Fraternal Grandfather			
Children			
Spouse/ Partner			

HEALTH HABITS
Breakfast:
Lunch:
Dinner:
Snacks:
Sweets:
Food Cravings:

Please describe past and present use of the following substances:
Alcohol:
Caffeine:
Tobacco:
Recreational drugs:

I certify that the above information is correct to the best of my knowledge. I will not hold my health practitioner or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed By Date