HEALTH HISTORY

Please complete all applicable questions to the best of your knowledge. If necessary, you may use the space at the end of this form to complete any answers or provide additional information.

Patient: _____ Date of Birth: ____ / ____ / _____

Home Address: _____

Marital Status: □ S □ M □ W □ D □ Sep Do you have a living will? □ Y □ N

MEDICAL CONDITIONS

If either you or a family member has or had any of these conditions, check (√) the box by the condition listed. For family member, indicate their relationship to you (e.g., mother, father, sibling). Please provide a brief description.

Condition	Self	Description	Family Member	Description
Arthritis				
Asthma				
Back Problems				
Blood in Stool				
Bowel Changes				
Cancer				
Chicken Pox				
Dental Problems				
Depression				
Diabetes				
Emphysema				
Hearing Problems				
Heart Problems				
Hepatitis				
High Blood Pressure				
High Cholesterol				
Kidney Problems				
Leg Swelling				
Liver Problems				
Lung Problems				
Measles				
Migraine Headaches				
Mononucleosis				
Mumps				
Panic Attacks				
Seizures				
Sexually Transmitted Disease				
Skin Problems				
Stroke				
Thyroid Problems				
Other:				
Other:				
Other:				

PROBLEM CHECKLIST

If you have recently or recurrently noted any of the following problems, please check (√) the box by the condition listed.

General	Fever Sweats Unintended weight change (how much for what period? _____)	Chills Malaise or "feeling ill" Fatigue
Head	Headache	Head Injury
Ears	Ringing Ear pain Ear discharge	Change in hearing Blockage Dizziness
Nose	Congestion Persistently discolored discharge Sinus pressure	Clear discharge Post nasal drip Sinus pain
Throat	Sore throat Laryngitis Itchy throat	Dental problem Persistent hoarseness Snoring
Eyes	Change in vision Flashing or scintillating lights Partial loss of vision Eye pain	Sudden loss of vision Dark spots or "floaters" Eye discharge Itchy or irritable
Heart	Chest pain or pressure Swelling of feet or ankles	Palpitations Racing Heart
Lungs	Trouble breathing Cough	Wheezing Painful breathing
Digestive	Heartburn or acid reflux Nausea Diarrhea Blood in stool Excessive bloating or gas	Abdominal pain Vomiting Constipation Black tarry stool
Bones and joints	Back pain Joint pain	Neck pain Muscle aches
Neurological	Weakness Abnormal sensations Seizures	Numbness Fainting Restless legs
Psychological	Anxious Feeling hopeless or helpless Unable to enjoy life Uncontrollable anger or irritability Wanting to hide, disappear or die	Panic attack Persistent sadness Insomnia Poor appetite or stress eating Wanting to hurt someone
Skin	Abnormal or changing mole Lesions of concern Swollen glands Change in texture	Rashes Dryness Bruising Hair or nail changes

ALLERGIES

Are you allergic or intolerant to any medications? □ Y □ N If "yes", please list and describe your reaction(s).

_____

_____

_____

SURGERIES

Please list any surgeries or procedures (include colonoscopies) you have had with approximate dates.

_____

_____

_____

MEDICATIONS
Please list any medications you are using including vitamins, herbal supplements and contraception.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PREVENTIVE HEALTH
Please provide the following information:

Caffeine? □ Y □ N Type:_____ Caffeinated beverages per day?	Alcohol? □ Y □ N Type:_____ Drinks per week? Quit Date? /
Tobacco? □ Y □ N Type: _____ Packs per day? Quit date? /	Other substances? □ Y □ N Frequency?_____ Drug(s)?
Exercise? □ Y □ N How long? Hrs/ Mins	Number of Days per week?

FOR WOMEN
Please provide the following information:

Number of pregnancies? How many resulted in live birth(s)? Miscarriage(s)? Abortion (s)?	
Date of last period? /	Could you be pregnant now? □ Y □ N
Last Pap Smear or female exam? /	Last mammogram? /
Method of birth control?	Age at first period? Age at menopause?
Prior abnormal Pap Smear? □ Y □ N If so, year:	Sexually active? □ Y □ N
History of human papilloma virus? □ Y □ N	Planning pregnancy in next year? □ Y □ N

Is there anything of a sensitive nature you would like to discuss with your physician? □ Y □ N

_____
_____
_____

ADDITIONAL INFORMATION
Please use this space to complete any of the above questions or provide other relevant information.

_____
_____
_____
_____
_____
_____

_____ _____
Patient Signature or Patient's Legal Representative Date

_____ _____
Print Name If not the patient, state your relationship to the patient or describe your authority to act on behalf of the patient.