

HEALTH HISTORY

(Confidential)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

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

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN only
<input type="checkbox"/> Chills	<input type="checkbox"/> Appetite poor	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Erection difficulties
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double vision	<input type="checkbox"/> Sore on penis
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Earache	<input type="checkbox"/> Other _____
<input type="checkbox"/> Headache	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Ear discharge	
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Gas	<input type="checkbox"/> Hay fever	WOMEN only
<input type="checkbox"/> Loss of weight	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Numbness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Sweats	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Extreme menstrual pain
	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Hot flashes
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Nipple discharge
	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Vision - Flashes	<input type="checkbox"/> Painful intercourse
		<input type="checkbox"/> Vision - Halos	<input type="checkbox"/> Vaginal discharge
			<input type="checkbox"/> Other _____
			Date of last menstrual period _____
			Date of last Pap Smear _____
			Have you had a mammogram? _____
			Are you pregnant? _____
			Number of children _____

CONDITIONS Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Measles	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Asthma	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Gout	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mumps	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Herpes	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease

MEDICATIONS List medications you are currently taking	ALLERGIES To medications or substances
Pharmacy Name _____ Phone _____	