

# HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Patient # \_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

**History of present illness:**

**Location:** \_\_\_\_\_  
(Where is the pain/problem?)

**Quality** \_\_\_\_\_  
(Example: normal versus abnormal color, activity, etc.)

**Severity** \_\_\_\_\_  
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

**Duration** \_\_\_\_\_  
(How long have you had this pain/problem?, or, When did it start?)

**Timing** \_\_\_\_\_  
(Does the pain/problem occur at a specific time?)

**Context** \_\_\_\_\_  
(Where were you at the onset of this pain/problem?)

**Associated signs/symptoms** \_\_\_\_\_  
\_\_\_\_\_  
(What other associated problems have you been having?)

**Modifying factors** \_\_\_\_\_  
\_\_\_\_\_  
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

**Past Medical History**

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

|                  |    |     |                              |    |     |                          |       |       |                   |       |       |
|------------------|----|-----|------------------------------|----|-----|--------------------------|-------|-------|-------------------|-------|-------|
| Measles          | no | yes | Anemia                       | no | yes | Back trouble             | no    | yes   | Hepatitis         | no    | yes   |
| Mumps            | no | yes | Bladder Infections           | no | yes | High Blood Pressure      | no    | yes   | Ulcer             | no    | yes   |
| Chickenpox       | no | yes | Epilepsy                     | no | yes | Low Blood Pressure       | no    | yes   | Kidney Disease    | no    | yes   |
| Whooping Cough   | no | yes | Migraine Headaches           | no | yes | Hemorrhoids              | no    | yes   | Thyroid Disease   | no    | yes   |
| Scarlet Fever    | no | yes | Tuberculosis                 | no | yes | Date of last chest x-ray | _____ | _____ | Bleeding Tendency | no    | yes   |
| Diphtheria       | no | yes | Diabetes                     | no | yes | Asthma                   | no    | yes   | Any other disease | no    | yes   |
| Smallpox         | no | yes | Cancer                       | no | yes | Hives or Eczema          | no    | yes   | (please list):    | _____ | _____ |
| Pneumonia        | no | yes | Polio                        | no | yes | AIDS or HIV+             | no    | yes   | _____             | _____ | _____ |
| Rheumatic Fever  | no | yes | Glaucoma                     | no | yes | Infectious Mono          | no    | yes   | _____             | _____ | _____ |
| Heart Disease    | no | yes | Hernia                       | no | yes | Bronchitis               | no    | yes   | _____             | _____ | _____ |
| Arthritis        | no | yes | Blood or Plasma Transfusions | no | yes | Mitral Valve Prolapse    | no    | yes   | _____             | _____ | _____ |
| Venereal Disease | no | yes |                              |    |     | Stroke                   | no    | yes   | _____             | _____ | _____ |

| Previous Hospitalizations/Surgeries/Serious Illnesses | When? | Hospital, City, State |
|---|-------|-----------------------|
| _____   | _____ | _____                 |
| _____   | _____ | _____                 |
| _____   | _____ | _____                 |

**Medications:** (Include nonprescription) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient social history:**

Marital status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_  
 Use of alcohol: Never: \_\_\_\_\_ Rarely: \_\_\_\_\_ Moderate: \_\_\_\_\_ Daily: \_\_\_\_\_  
 Use of tobacco: Never: \_\_\_\_\_ Previously, but quit: \_\_\_\_\_ Current packs / day: \_\_\_\_\_  
 Use of drugs: Never: \_\_\_\_\_ Type/Frequency: \_\_\_\_\_  
 Excessive exposure at home or work to: Fumes: \_\_\_\_\_ Dust: \_\_\_\_\_ Solvents: \_\_\_\_\_ Air-borne Particles: \_\_\_\_\_ Noise: \_\_\_\_\_

**Family medical history:**

|          | Age   | Diseases | If Deceased, Cause of Death |
|----------|-------|----------|-----------------------------|
| Father   | _____ | _____    | _____                       |
| Mother   | _____ | _____    | _____                       |
| Siblings | _____ | _____    | _____                       |
|          | _____ | _____    | _____                       |
| Spouse   | _____ | _____    | _____                       |
| Children | _____ | _____    | _____                       |
|          | _____ | _____    | _____                       |
|          | _____ | _____    | _____                       |

**Review of Systems: Please indicate any personal history below:**

**Constitutional Symptoms**

Good general health lately . . . . No Yes  
 Recent weight change . . . . . No Yes  
 Fever . . . . . No Yes  
 Fatigue . . . . . No Yes  
 Headaches . . . . . No Yes

**Eyes**

Eye disease or injury . . . . . No Yes  
 Wear glasses/contact lenses . . . . No Yes  
 Blurred or double vision . . . . . No Yes

**Ears/Nose/Mouth/Throat**

Hearing loss or ringing . . . . . No Yes  
 Earaches or drainage . . . . . No Yes  
 Chronic sinus problem or rhinitis . . No Yes  
 Nose bleeds . . . . . No Yes  
 Mouth sores . . . . . No Yes  
 Bleeding gums . . . . . No Yes  
 Bad breath or bad taste . . . . . No Yes  
 Sore throat or voice change . . . . No Yes  
 Swollen glands in neck . . . . . No Yes

**Cardiovascular**

Heart trouble . . . . . No Yes  
 Chest pain or angina pectoris . . . . No Yes  
 Palpitation . . . . . No Yes  
 Shortness of breath w/walking  
 or lying flat . . . . . No Yes  
 Swelling of feet, ankles or hands . . No Yes

**Respiratory**

Chronic or frequent coughs . . . . . No Yes  
 Spitting up blood . . . . . No Yes  
 Shortness of breath . . . . . No Yes  
 Wheezing . . . . . No Yes

**Gastrointestinal**

Loss of appetite . . . . . No Yes  
 Change in bowel movements . . . . . No Yes  
 Nausea or vomiting . . . . . No Yes  
 Frequent diarrhea . . . . . No Yes  
 Painful bowel movements  
 or constipation . . . . . No Yes  
 Rectal bleeding or blood in stool . . No Yes  
 Abdominal pain . . . . . No Yes

**Genitourinary**

Frequent urination . . . . . No Yes  
 Burning or painful urination . . . . . No Yes  
 Blood in urine . . . . . No Yes  
 Change in force of strain  
 when urinating . . . . . No Yes  
 Incontinence or dribbling . . . . . No Yes  
 Kidney stones . . . . . No Yes  
 Sexual difficulty . . . . . No Yes  
 Male - testicle pain . . . . . No Yes  
 Female - pain with periods . . . . . No Yes  
 Female - irregular periods . . . . . No Yes  
 Female - vaginal discharge . . . . . No Yes  
 Female - # of pregnancies . . . . . \_\_\_\_\_  
 Female - # of miscarriages . . . . . \_\_\_\_\_  
 Female - date of last pap smear \_\_\_\_\_

**Musculoskeletal**

Joint pain . . . . . No Yes  
 Joint stiffness or swelling . . . . . No Yes  
 Weakness of muscles or joints . . . . No Yes  
 Muscle pain or cramps . . . . . No Yes  
 Back pain . . . . . No Yes  
 Cold extremities . . . . . No Yes  
 Difficulty in walking . . . . . No Yes

**Integumentary (skin, breast)**

Rash or itching . . . . . No Yes  
 Change in skin color . . . . . No Yes  
 Change in hair or nails . . . . . No Yes  
 Varicose veins . . . . . No Yes  
 Breast pain . . . . . No Yes  
 Breast lump . . . . . No Yes  
 Breast discharge . . . . . No Yes

**Neurological**

Frequent or recurring headaches . . . No Yes  
 Light headed or dizzy . . . . . No Yes  
 Convulsions or seizures . . . . . No Yes  
 Numbness or tingling sensations . . . No Yes  
 Tremors . . . . . No Yes  
 Paralysis . . . . . No Yes  
 Head injury . . . . . No Yes

**Psychiatric**

Memory loss or confusion . . . . . No Yes  
 Nervousness . . . . . No Yes  
 Depression . . . . . No Yes  
 Insomnia . . . . . No Yes

**Endocrine**

Glandular or hormone problem . . . . No Yes  
 Excessive thirst or urination . . . . . No Yes  
 Heat or cold intolerance . . . . . No Yes  
 Skin becoming dryer . . . . . No Yes  
 Change in hat or glove size . . . . . No Yes

**Hematologic/Lymphatic**

Slow to heal after cuts . . . . . No Yes  
 Bleeding or bruising tendency . . . . No Yes  
 Anemia . . . . . No Yes  
 Phlebitis . . . . . No Yes  
 Past transfusion . . . . . No Yes  
 Enlarged glands . . . . . No Yes

**Allergic/Immunologic**

History of skin reaction or other adverse  
 reaction to:  
 Penicillin or other antibiotics . . . . . No Yes  
 Morphine, Demerol,  
 or other narcotics . . . . . No Yes  
 Novocain or other anesthetics . . . . . No Yes  
 Aspirin or other pain remedies . . . . No Yes  
 Tetanus antitoxin  
 or other serums . . . . . No Yes  
 Iodine, Merthiolate or  
 other antiseptic . . . . . No Yes  
 Other drugs/medications: \_\_\_\_\_

Known food allergies: \_\_\_\_\_

Environmental allergies: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

\_\_\_\_\_  
 Signature of Patient, Parent or Guardian

\_\_\_\_\_  
 Date

**Doctor's Review**

\_\_\_\_\_  
 Signature of Doctor

\_\_\_\_\_  
 Date