Health History

Welcome to our practice. Please fill out the information below to the best of your ability.

Name ______________________ Birthdate __________ Birthplace ______________

Occupation ______________________ Height __________ Weight __________

Referred by ______________________ Primary Care Physician ______________________

Chief Complaint ____

HISTORY OF PRESENT ILLNESS

Location ______________________ Quality ______________________
Where is the pain/problem? — Example: normal versus abnormal color, activity, etc.

Severity ______________________ Duration ______________________
How severe is the problem on a scale of 1-5 with 5 being most severe? — How long have you had this pain/problem? When did it start?

Timing ______________________ Context ______________________
Does the pain/problem occur at a specific time? — 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? Have you had previous episodes?

PAST MEDICAL HISTORY

Have you ever had the following? Check yes or no, leave blank if uncertain.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Measles	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Mumps	☐ Yes	☐ No	Bleeding Tendency	☐ Yes	☐ No	Acid Reflux	☐ Yes	☐ No
Chickenpox	☐ Yes	☐ No	HIV	☐ Yes	☐ No	Peptic Ulcer	☐ Yes	☐ No
Whooping Cough	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No	Eczema	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No	Chronic Bronchitis	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Diphtheria	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Sleep Apnea	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	If yes, circle one	A B	C
Tonsillectomy	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Other Disease	☐ Yes	☐ No
			Please list type: ______			Please list type: ______		

Please list all previous hospitalizations/surgeries/serious illnesses.

Description ______________________ Date __________

Description ______________________ Date __________

Description ______________________ Date __________

Description ______________________ Date __________

Description ______________________ Date __________

Description ______________________ Date __________

Current Medications (include nonprescription/herbals/vitamins) please include dosages and instructions:

Medication ______________________________ Dosage ______________

Medication ______________________________ Dosage ______________

Medication ______________________________ Dosage ______________

Medication ______________________________ Dosage ______________

Drug Allergies (with reactions) ______________________________

Pharmacy Name ______________ Location ______________ Phone ______________

PATIENT SOCIAL HISTORY

Marital Status	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
If Under 18, Parents are	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Use of Alcohol	☐ Never	☐ Rarely	☐ Moderate	☐ Daily	

Use of Tobacco ☐ Never Current Packs per Day ______ # Years Smoked ______ ☐ Previously, but Quit

Packs per Day ______ Age Started ______ Age Stopped ______

Use of Drugs ☐ Never Type/Frequency ______________________________

Excessive Exposure to ☐ Fumes ☐ Dust ☐ Solvents ☐ Noise ☐ Air-Borne Particles

FAMILY MEDICAL HISTORY

	Age		Diseases	If Deceased, Cause of Death
Father	________		______________________	______________
Mother	________		______________________	______________
Siblings	________	B/S	______________________	______________
Siblings	________	B/S	______________________	______________
Siblings	________	B/S	______________________	______________
Children	________		______________________	______________
Children	________		______________________	______________
Children	________		______________________	______________

Review of Systems: Please indicate any SIGNIFICANT personal history below.

CONSTITUTIONAL SYMPTOMS		**EARS/NOSE/MOUTH/THROAT**		**GENITOURINARY**	
Good General Health lately	☐ Yes ☐ No	Hearing Loss	☐ Yes ☐ No	Prostate Hypertrophy	☐ Yes ☐ No
Recent Weight Change	☐ Yes ☐ No	Ringing in Ears	☐ Yes ☐ No	Difficulty Urinating	☐ Yes ☐ No
Fever	☐ Yes ☐ No	Earaches	☐ Yes ☐ No	Kidney Stones	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No	Ear Drainage	☐ Yes ☐ No	Female # of Pregnancies	________
Headaches	☐ Yes ☐ No	Chronic Sinus Infections	☐ Yes ☐ No	Are you pregnant now?	☐ Yes ☐ No
EYES		Chronic Nasal Congestion	☐ Yes ☐ No	**MUSCULOSKELETAL**	
Eye Disease	☐ Yes ☐ No	Nose Bleeds	☐ Yes ☐ No	Neck Trouble	☐ Yes ☐ No
Eye Injury	☐ Yes ☐ No	Mouth Sores	☐ Yes ☐ No	Back Trouble	☐ Yes ☐ No
Wear Glasses or Contact Lenses	☐ Yes ☐ No	Sore Throat	☐ Yes ☐ No	Difficulty Walking	☐ Yes ☐ No
Blurred Vision	☐ Yes ☐ No	Voice Change	☐ Yes ☐ No	**INTEGUMENTARY (SKIN)**	
Double Vision	☐ Yes ☐ No	Swollen Glands in Neck	☐ Yes ☐ No	Rash	☐ Yes ☐ No
CARDIOVASCULAR		**RESPIRATORY**		Itching	☐ Yes ☐ No
Heart Trouble	☐ Yes ☐ No	Chronic or Frequent Coughs	☐ Yes ☐ No	Hives	☐ Yes ☐ No
Chest Pain or Angina Pectoris	☐ Yes ☐ No	Spitting up Blood	☐ Yes ☐ No	Keloids	☐ Yes ☐ No
Palpitations	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Skin Cancer	☐ Yes ☐ No
Swelling of Feet, Ankles or Hands	☐ Yes ☐ No	Wheezing	☐ Yes ☐ No	**NEUROLOGICAL**	
				Chronic Headaches	☐ Yes ☐ No
				Neurological Disease	☐ Yes ☐ No
				Head Injury	☐ Yes ☐ No

PSYCHIATRIC		ALLERGIC	
Memory Loss	☐ Yes ☐ No	History of skin reaction or other adverse reaction to:	
Confusion	☐ Yes ☐ No	Penicillin Antibiotics	☐ Yes ☐ No
Nervousness	☐ Yes ☐ No	Narcotics	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Anesthetics	☐ Yes ☐ No
Insomnia	☐ Yes ☐ No	Asprin or Other Pain Remedies	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Iodine	☐ Yes ☐ No
GASTROINTESTINAL		Known Food Allergies:	
Loss of Appetite	☐ Yes ☐ No		
Nausea or Vomiting	☐ Yes ☐ No		
Insomnia	☐ Yes ☐ No	Environmental Allergies:	
Diarrhea	☐ Yes ☐ No		
Constipation	☐ Yes ☐ No		
Heartburn	☐ Yes ☐ No		

Other Important Information Not Included in Health History (ie: prior treatment, lab/imagining tests, procedures, etc):

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