

Health History

Name: _____

Today's Date: _____

Please select all choices that apply to the patient.

- | | | | | | |
|--|--|---|---|--|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Irritable Colon | <input type="checkbox"/> PMS | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Colitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Profuse Menstrual | <input type="checkbox"/> Spinal Disc Disorder |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irregular Bowel Habits | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Irregular Menstrual | <input type="checkbox"/> Painful Urination | | |

Select all choices that apply to the patient's family (please do not include relations by marriage.)

- | | | | | | |
|--|--|---|---|--|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Irritable Colon | <input type="checkbox"/> PMS | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Polio | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Colitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Profuse Menstrual | <input type="checkbox"/> Spinal Disc Disorder |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Rapid Heart Rate | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizziness | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irregular Bowel Habits | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Irregular Menstrual | <input type="checkbox"/> Painful Urination | | |

Patient exercises: Moderately Occasionally Rarely Regularly Never

Patient smokes: 2 packs per day 1/2+ packs per day Never _____ _____
 2+ packs per day 1 packs per day 1/2 packs a day or less _____ _____

Patient uses alcohol: Excessively Moderately Occasionally Rarely Never

Medication the patient is currently taking: Muscle Relaxants No prescription Psychotropic _____
 Analgesics Birth Control No non-prescription medications medication _____
 Anti-Inflammatory Hypertension medication Tranquilizers Vitamin supplements _____

Allergies - please mark all that apply: Dust Penicillin Pollen Sulfa Drugs
 Animal Dander Dairy Products Latex Perfumes Secondary Smoke No known allergies

Past Surgical History

Date: _____ Type of Surgery: _____ Where: _____ Surgeon: _____

Complications/Remaining Problems: _____

Past Hospitalizations

Cause of Hospitalizations: _____

Date: _____ Complications/Remaining Problems: _____

I understand that the information I have provided above is current and complete to the best of my knowledge.

Initial: _____

-Family history-

	Age	Health Problem or Cause of Death
Mother		
Father		
Grandparents		
Brothers		
Sisters		
Children		