HEALTH HISTORY

DATE
LAST NAME
FIRST NAME
DATE OF BIRTH
AGE

Do you have an advance directive (AD) ? YES_____ NO _____
Do you have a Health Care Power of attorney (HCPA)? YES_____ NO _____
Would you like information regarding AD or HCPA? YES_____ NO _____

Please check the items which pertain to your present or past medical conditions.

PRESENT SYMPTOM

HOW LONG?

PAST MEDICAL HISTORY:

CURRENT MEDS

DRUG ALLERGIES

Latex Allergies
Seasonal Allergies

SURGERIES

GALL BLADDER
APPENDIX
CATARACTS
OTHER

(FEMALES ONLY)

UTERUS
OVARIES
TUBAL LIGATION
OTHER

(MALES ONLY)

PROSTATE
VASECTOMY
OTHER

HOSPITALIZATIONS

BLOOD TRANSFUSION

TRAUMA / ACCIDENTS

PAST MEDICAL PROBLEMS

HIGH BLOOD PRESSURE
DIABETES
CARDIAC DISEASE
HEART ATTACK
PEPTIC ULCER
ASTHMA
EMPHYSEMA
THYROID DISEASE
KIDNEY DISEASE
BLEEDING DISORDER
CANCER
TUBERCULOSIS
HEPATITIS
OSTEOPEROSIS

PAST PSYCH HISTORY

DEPRESSION
HOSPITALIZATIONS
ALCOHOL DEPENDENCE

IMMUNIZATIONS

PNEUMOCOCCAL VACCINE
FLU SHOT
TETANUS
CHILDHOOD

(FEMALE PATIENTS ONLY)

GYNECOLOGIC HISTORY

G P A L

NORMAL PAP
NORMAL DELIVERIES
SELF BREAST EXAM
NORMAL MAMMOGRAM
C-SECTIONS
PHYSICAL

FAMILY ILLNESSES

HIGH BLOOD PRESSURE
DIABETES
CARDIAC DISEASE
HEART ATTACK
PEPTIC ULCER
ASTHMA
EMPHYSEMA
THYROID DISEASE
KIDNEY DISEASE
BLEEDING DISORDER
CANCER
TUBERCULOSIS
HEPATITIS
OSTEOPEROSIS

FATHER
AGE
LIVING

MOTHER
AGE
LIVING

SOCIAL HISTORY

MARITAL STATUS
CHILDREN
AGES

OCCUPATION

PRESENT

PAST

RECENT TRAVEL

EDUCATION

EXPOSURE TO AGENTS

HABITS

SMOKER
ALCOHOL
CAFFEINE
EXERCISE
DRUGS

SAFETY

Do you use sunscreen?
Do you own firearms?
Do you use seatbelts?

REVIEW OF SYSTEMS

GENERAL:

WEIGHT CHANGES
GAIN / LOSS
HEIGHT
FATIGUE
WEAKNESS
CHANGE IN APPETITE
FEVERS / CHILL
NIGHT SWEAT

SKIN

RASH
ITCHINESS
DRYNESS
SKIN CANCER
OTHER LESIONS

HEAD

TRAUMA
HEADACHE
MIGRAINES
DIZZINESS
FAINTING SPELLS

EYES

NORMAL VISION
BLINDNESS
GLASSES
NEW PRESCRIPTION
PHOTOPHOBIA
BLURRING
DOUBLE VISION
SPOTS
REDNESS
DISCHARGE
DRY EYES
EXCESSIVE TEARING
CATARACTS
GLAUCOMA

EARS

HEARING CHANGES
RINGING IN EARS
PAIN
DISCHARGE
VERTIGO
EAR INFECTIONS

NOSE

SINUS PROBLEMS
NOSE BLEEDS
OBSTRUCTION
POLYPS
SENSE OF SMELL

THROAT

BLEEDING GUMS
DENTALCAVITIES
LESIONS ON TONGUE
GUMS
DENTURES

RESPIRATORY

CHEST PAIN
SNEEZING
SHORT OF BREATH
COUGH
SPUTUM COLOR CHANGE
COUGHING BLOOD
PNEUMONIA
INFLUENZA
POSITIVE TB TEST
VALLEY FEVER

CARDIOVASCULAR

CHEST PAIN
CHEST PRESSURE
SHORT OF BREATH
CAN'T SLEEP FLAT
MURMURS
CLAUDICATION
CONGESTIVE HEART FAILURE
NIGHT TIME COUGH

GASTROINTESTINAL

CAN'T SWALLOW FOOD
HEARTBURN
NAUSEA
VOMITING
VOMITING BLOOD
INDIGESTION
ABDOMINAL PAIN
DIARRHEA
CONSTIPATION
VERY DARK STOOLS
BLOOD IN STOOLS
HEMORRHOIDS
CHANGE IN STOOL
JAUNDICE
FOOD INTOLERANT
SIGMOIDOSCOPY
COLONOSCOPY

GYNECOLOGIC

(FEMALE ONLY)
PERIOD STARTED AT AGE
LAST MENSTRUAL PERIOD

CRAMPING
SPOTTING
MENOPAUSE
CONTRACEPTION
ABNORMAL FLOW

SEXUAL HISTORY

VENEREAL DISEASE
MULTIPLE PARTNERS
NUMBER PARTNERS
CONTRACEPTION

ONCOLOGY

CANCER
SKIN CANCER
COLON CANCER
LUNG CANCER
BREAST CANCER
THYROID CANCER
STOMACH CANCER

GENITOURINARY

FREQUENT URINATION
SMALL VOLUME OF URINE
HESITANCY
PAIN ON URINATION
BLOOD IN URINE
ODOR IN URINE
WAKE UP FREQUENTLY
INCONTINENT OF URINE
VENEREAL DISEASE
DISCHARGE
STERILITY
IMPOTENCE
CHANGE IN STREAM
CAN'T START STREAM
CAN'T STOP STREAM

ENDOCRINE

DIABETES
LOW THYROID
HIGH THYROID
FATIGUE
WEAKNESS
HORMONE THERAPY
CHANGE IN SKIN

MUSCULOSKELETAL

JOINT PAIN
ARTHRIATIS
TRAUMA
JOINT SWELLING
REDNESS
JOINT TENDERNESS
LIMITED RANGE OF MOTION
BACK PAIN
NECK PAIN
GOUT
SPORTS INJURY

PERIPHERAL VASCULAR

VARICOSE VEINS
INTERMITTENT CLAUDICATION
THROMBOPHLEBITIS
BLOOD CLOTS

HEMATOLOGY

ANEMIA
BLEEDING
EASY BRUISING
ENLARGED LYMPH NODES

NEUROPSYCHIATRIC

FAINTED
SEIZURES
WEAKNESS
ABNORMAL COORDINATION
ABNORMAL SENSATIONS
POOR MEMORY
DEPRESSED MOOD
POOR SLEEP PATTERN
EMOTIONAL DISTRUBANCES

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