Health History Form

Name:

Address:

Phone #(s):

Email:

Emergency Contact Name:

Phone #(s):

Relation to self:

Name of physician*:

Address:

Phone #:

Date of last physician appointment:

Name of other physician / care giver* (ex. gynecologist, cardiologist, psychologist):

Address:

Phone #:

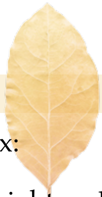
Name of other physician / care giver*:

Address:

Phone #:

Main symptoms and concerns:

* No contact will be made with physicians / care givers without your permission.



Sex:

Height and weight:

Age:

Date of birth:

Relationship status:

Education:

Occupation:

Family History: Indicate any illness for self and / or family member by placing a date or an "X" (when not known) in appropriate boxes.

	Self	Mother	Father	Sibling	Partner	Children
Adopted						
Good health						
Cancer / Tumors						
Diabetes						
Thyroid disorders						
Kidney disorders						
High blood pressure / Heart disease						
Stroke						
Blood disorders / Anemia						
Seizures						
Allergies						
Alcohol / Drug use						
Depression /Mental Illness						
Hepatitis / Liver disorders						
Musculo-skeletal disorders						
HIV / AIDS						
Deceased	NA					

Current and Past Conditions / Symptoms Mark with a "C" for current conditions, a "P" for past conditions, or a "P/C" if you have experienced the condition both in the past and currently.

General

____ Insomnia

____ Dreams / nightmares

____ Fatigue

____ Poor memory

____ Likes cold drinks

____ Likes hot drinks

____ Recent weight loss / gain

____ Cold hands / feet

____ Chills

____ Fever

____ Bad breath

____ Other (describe)

____

Head & Neck

____ Headaches

____ Migraines

____ Stiff neck

____ Dizziness

____ Fainting

____ Swollen glands

____ Other (describe)

____

Nose, Throat, Mouth

____ Sinus Infection

____ Hay fever / allergies

____ Frequent sore throat

____ Difficulty swallowing

____ Mouth and tongue ulcers

____ Frequent colds

____ Nosebleed

____ Dry nose

____ Nasal Congestion

____ Loss of voice

____ Thirst

____ Excessive phlegm

____ TMJ (temporomandibular joint disorder)

____ Facial pain

____ Gum problems

____ Dry mouth

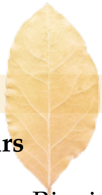
____ Dental problems (describe)

____

____

____ Other (describe)

____



Ears

____ Ringing

____ Hearing loss

____ Hearing aids

____ Infections

____ Earache

____ Vertigo

____ Other (describe)

____

Eyes

____ Glasses / contact lenses

____ Blurred vision

____ Poor night vision

____ Spots or floaters

____ Eye inflammation

____ Double vision

____ Glaucoma

____ Cataracts

____ "Lazy" eye

____ Other (describe)

____

____ How often checked?

____

Skin

____ Hives

____ Rashes

____ Eczema / psoriasis

____ Dry skin

____ Easily bruised

____ Changes in moles, lumps

____ Itching

____ Night sweating

____ Excessive sweating

____ Other (describe)

____

Respiratory

____ Difficulty breathing

____ Difficulty breathing while reclining

____ Wheezing

____ Asthma

____ Chronic cough

____ Wet cough

____ Dry cough

____ Coughing up phlegm

____ Coughing up blood

____ Shortness of breath

____ Tight chest

____ Pneumonia

____ Other (describe)

____

Cardiovascular

____ High blood pressure

____ Low blood pressure

____ Chest pain or tightness

____ Palpitation

____ Rapid heart beat

____ Irregular heart beat

____ Poor circulation

____ Swollen ankles

____ Phlebitis

____ Anemia

____ History of heart disease

____ Heart murmur

____ Other (describe)

____

Musculoskeletal

____ Joint pain / swelling

____ Sore muscles

____ Weak muscles

____ Difficulty walking

____ Limited range of motion (describe)

____

____ Pain (describe)

____

____

____ Other (describe)

____

Gastrointestinal

____ Nausea

____ Indigestion

____ Stomach pain

____ Diarrhea

____ Constipation

____ Poor appetite

____ Excessive hunger

____ Vomiting

____ Gas

____ Hiccups

____ Acid regurgitation

____ Bloating

____ Laxative use

____ Bloody stool

____ Other

____

Neurological

____ Seizures

____ Tremors

____ Numbness or tingling

____ Paralysis

____ Poor circulation

____ Pain (describe)

____

____

____ Other (describe)

Mental / Emotional

____ Depression

____ Mood swings

____ Irritability

____ Difficulty relaxing

____ Loneliness

____ Sensitive

____ Shyness

____ Frequent crying

____ Worries frequently

____ Compulsive behavior

____ Difficulty focusing

____ Hopeless outlook

____ Suicidal thoughts

____ Lose temper

____ Frustration

____ Other (describe)

____

Male Genital

____ Impotence

____ Premature ejaculation

____ Nocturnal emission

____ Pain / itching of genitals

____ Lumps in testicles

____ Increased libido

____ Decreased libido

____ Other (describe)

Urinary

____ Pain on urination

____ Frequent urination

____ Urgent urination

____ Blood in urine

____ Incontinence

____ Incomplete urination

____ Bedwetting

____ Wake to urinate

____ Kidney issues (describe)

____

____

____ Other (describe)

____

Infection Screening (circle all that applies)

____ HIV risks: self or partner

____ TB: self / partner / household

____ Hepatitis risk: self or partner

____ History of sexually transmitted disease:

self or partner (describe)

____

____

____ Other

____

Gynecology

Date of last appointment:

____ Currently pregnant

____ # of pregnancy

____ # of live births

____ # of miscarriages

____ # of abortions

____ Perimenopause

____ Menopause

____ Irregular period

____ Menstrual cramps

____ Excessive blood flow

____ Menstrual blood clots

____ Breast tenderness

____ Abnormal pap smear

____ Vaginal infections

____ Vaginal pain / itching

____ Uterine fibroids

____ Endometriosis

____ Breast lumps, cysts

____ Increased libido

____ Decreased libido

____ Other (describe)

____

Trauma (describe)

____

____

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____

____

Other Information

____

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____

Personal Lifestyle Habits: Indicate how many and how often for each item, or date you quit.

Cigarettes (packs / day):

Coffee / Tea (cups / day):

Alcohol (drinks / week):

Exercise (days / week):

Medical: If you have ever been hospitalized or in the emergency room for a medical illness or operation describe below. (Do not include normal pregnancies.)

Operation / Illness and year:

Operation / Illness and year:

Operation / Illness and year:

____ Check here if continued on attached sheet?

Medicines: What prescription medicines and over the counter medicines are you currently taking? Include dosage and for what condition.

Prescription:

Prescription:

Prescription:

Prescription:

Over the counter medicine:

____ Check here if continued on attached sheet?

Supplements (vitamins, herbs, homeopathic, ect.): Include dosage and for what condition.

Supplement:

Supplement:

Supplement:

Supplement:

____ Check here if continued on attached sheet?

Thank you!

Patient Signature: ______________________________ Date: ______________