Health History

Main issue today? _____
_____
_____

Allergies / Reactions: (List medications, foods, latex, insects, and describe reactions)
_____

Medications, vitamins, and OTC products: (List and describe what condition treated)
_____
_____
_____

Personal History: Occupation: _____ Education: _____

Family Situation: Single Married Partnered Separated Divorced Widowed

Who do you live with? _____

Have you ever been hurt or touched inappropriately? Yes No If yes, are you safe now? Yes No

Guns at home? Yes No Are they secured? If so, how? _____

Hobbies and/or pets? _____ Spiritual preferences (if any) _____

Exercise Habits: _____ Coffee #/day: _____ Soda #/day: _____

Nutritional Habits: How many servings of fruits, vegetables, and dairy? _____

Driving Habits: (% of the time) Seatbelts: _____ Helmets: _____ No. of Accidents/DUIs: ___

Drugs of Habit: Tobacco: Yes No Type & Quantity: _____ Age of Start/Stop: _____

Nonprescription drug use: Yes No Type & Frequency: _____ Marijuana use: Yes No

Alcohol use: Yes No Frequency & Quantity: _____ Age of Start/Stop: _____

Sexual Preference: Men Women Both Neither Do you use condoms? Always Sometimes No

Gender identity: _____ Preferred pronouns: she - he - they

Females: Age of first menstrual period: _____ Age of first birth: _____ Breast fed: Yes No

Last menstrual period: _____ # of Pregnancies: _____ # of Deliveries: _____

# of Miscarriages: ____ # of Abortions: ____ # of Children: _____ Complications? _____

Date of last Tetanus vaccine? _____ Pneumonia? _____ Hepatitis? _____ Flu? _____
Do you have Advanced Directives, Living Will, or Power of Attorney for Healthcare Decisions? ____
(If yes, please provide a copy to us for your chart in case of emergency.)

Patient: _____ DOB: _____ Date: _____

Health History

Review of Systems: Circle any symptoms you have. If all in each section negative/normal, circle N.

General	N	fever chills fatigue pain appetite changes sexual issues
Eye/Head	N	Blurry/double vision light-sensitive itchy spots watering dry Contacts/glasses Headaches – daily/occasional
Ears	N	Hearing change/loss itchy pain clogged ringing crickets
Nose	N	Smelling change bleeding clogged runny congestion
Mouth	N	Taste change bleeding pain dental problems
Throat	N	Swallowing problems hoarseness pain swollen snoring
Muscles/Joints	N	Pain stiffness swelling back problems cramping
Allergy/Immune	N	Hayfever rashes sneezing nasal congestion breathing problems
Respiratory	N	Hard to breathe (walking/lying/climbing) wheezing coughing blood
Cardiovascular	N	Pain pressure tightness irregular/rapid heartbeat flutters
Gastrointestinal	N	Pain burning indigestion reflux nausea vomiting constipation diarrhea blood gas belching hemorrhoids bloating changes
Genitourinary	N	Burning leaking bleeding hard to start dribbling urgent
Endocrine	N	Loss of hair nail changes skin changes temperature intolerance increased urination thirsty weight gain/loss
Prostate	N	Weak stream incomplete emptying frequent starts and stops strains
Skin	N	Sweating dry oily moles changes rashes warts ulcers
Breasts	N	Lumps pain discharge shoulder pain
Gynecological	N	Vaginal pain itching discharge dryness hot flashes irregular heavy
Neuro/Brain	N	Nervous stress decreased memory depressed anxious dizzy personality change numbness tingling weakness speech problems
Blood/Lymph	N	Bruises swelling tender glands pale

What is your general perception of your health and quality of life?

Delighted - Happy - Mostly Satisfied - Mixed - Mostly Disappointed - Unhappy - Terrible

Patient: _____ DOB: _____ Date: _____

Health History

Previous illnesses and chronic conditions:

Diabetes	Head trauma	Back problems	HIV/AIDS
Thyroid disease	Stroke	Joint problems	Addictions
Allergies	Glaucoma	Heart disease	Kidney stone/disease
Asthma	Cataracts	Palpitations	Bladder disease
COPD/Emphysema	Hearing problems	Ulcers/GERD	Blood clots
Hypertension	Depression	Irritable bowel synd.	Sleep disorder
High cholesterol	Anxiety	Indigestion/belching	STDs
Seizures	Pain issues	Hepatitis	Cancers

Previous surgeries and hospitalizations:

Tonsillectomy	Gallbladder	Hysterectomy	Knee replacement
Ear tubes	Hernia	Ovaries removed	Cataracts
Appendectomy	Vasectomy	Prostate surgery	Tubal ligation
Cosmetic	Cardiac surgery	Hip replacement	Biopsy

Caesarean section(s) _____

Other surgeries _____

Details:

_____

_____

_____

Family History: fill in chart below (use back of page if more space needed)

Relative		*Age Now or at Death*	*Diseases/Disorders, Cause of Death (if applicable)*
Father			
Mother			
Father's mom			
Father's dad			
Mother's mom			
Mother's dad			
	( )		
Aunt (A)/Uncle (U)	( )		
	( )		
Brother(B) / Sister(S)	( )		
	( )		
Son(s) / Daughter (d)	( )		
	( )		

Patient: _____ DOB: _____ Date: _____