

# Patient Health History

Name: \_\_\_\_\_  
SSN: \_\_\_\_\_

Date: \_\_\_\_\_  
DOB: \_\_\_\_\_

**Chief Complaint:** What is the reason for your visit today? (Please describe problem in detail including history of present illness): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History:** Please check all that apply to you:

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Epilepsy/seizures   | <input type="checkbox"/> Psychiatric disease |
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart surgery       | <input type="checkbox"/> Thyroid             |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> None                |

**Previous Surgeries:** Please list past surgeries with approximate date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Serious Injury:** Please describe any serious injuries you have had: \_\_\_\_\_  
\_\_\_\_\_

**Medications:** Please list any medications you are taking with dose and frequency:

| <i>Drug</i> | <i>Dose/Frequency</i> |
|-------------|-----------------------|
| _____       | _____                 |
| _____       | _____                 |
| _____       | _____                 |

**Allergies:** please list any allergies that you have \_\_\_\_\_  
\_\_\_\_\_

**Social History:**

Do you drink alcohol? Yes No If yes, how much/week? \_\_\_\_\_  
Do you smoke? Yes No If yes, how many cigarettes/day? \_\_\_\_\_  
Do you consume caffeine? Yes No If yes, how many cups/week? \_\_\_\_\_  
Do you use recreation drugs? Yes No If yes, what type and frequency? \_\_\_\_\_  
Are you on a special diet? Yes No If yes, please describe? \_\_\_\_\_

**Family History:** Do you know of any blood relative who has or had:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Multiple Sclerosis  |
| <input type="checkbox"/> Aneurysm          | <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Psychiatric Disease |
| <input type="checkbox"/> Brain Tumor       | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Cancer, Type:     | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Thyroid             |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> None                |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Migraine            |  |

**Comments:**

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As you review the following list, please check any problems or conditions, that you are experiencing or have experienced. If you do not have any of the problems listed in the section please check none.

## General Health

- Good general health
- Recent weight change
- Loss of appetite
- Fatigue
- Fever/chills

## Allergy

- Drug allergies
- Food allergies
- Hay fever
- Other: \_\_\_\_\_
- None

## Ears, Nose, Mouth, Throat

- Difficulty swallowing
- Earaches
- Loss of hearing/deafness
- Loss of smell
- Loss of taste
- Painful chewing
- Ringing in ears
- Sinus infection
- Sores in mouth
- None
- Other: \_\_\_\_\_

## Eyes

- Blind spots
- Blurred vision
- Double vision
- Loss of vision
- Glaucoma
- Injury
- Pain
- Other: \_\_\_\_\_
- None

## Gastrointestinal

- Blood in stools
- Increasing constipation
- Nausea
- Painful bowel movements
- Persistent diarrhea
- Stomach or abdominal pain
- Ulcer
- Vomiting
- Other: \_\_\_\_\_
- None

## Genitourinary

- Blood in urine
- Female: irregular periods
- Female: #pregnancies \_\_\_\_\_  
#miscarriages \_\_\_\_\_
- Female: vaginal discharge
- Kidney stones
- Male: prostate disease
- Male: testicle pain
- Painful or burning urination
- Sexual difficulty
- Sexually transmitted disease
- Urgency with urination
- Urine retention/  
incontinence
- Other: \_\_\_\_\_
- None

## Heart and Lungs

- Pain in chest
- High blood pressure
- High cholesterol
- Irregular heart beat
- Other: \_\_\_\_\_
- None

## Muscles/Joints/Bones

- Back pain
- Difficulty walking
- Joint pain
- Joint stiffness or swelling
- Muscle pain or tenderness
- Neck pain
- None

## Neurological

- Balance trouble
- Black outs/loss of  
consciousness
- Difficulty speaking
- Difficulty walking
- Facial drooping
- Headaches
- Injury to the brain or spine
- Light-headed or dizziness
- Memory loss
- Mental Confusion
- Migraines
- Mini stroke

- Neuropathy
- Numbness or tingling
- Paralysis
- Stroke
- Tremors
- Weakness
- Other: \_\_\_\_\_
- None

Are you?  right handed  
 left handed  
 Both

## Psychiatric

- Depression
- Anxiety
- Eating disorder
- Other: \_\_\_\_\_
- None

## Pulmonary

- Asthma
- Blood in cough
- Cancer
- Chronic or frequent cough
- Emphysema
- Pneumonia
- Shortness of breath
- Other: \_\_\_\_\_
- None

## Skin

- Rash or itching
- Sun sensitivity
- Hair loss
- Color changes
- Other: \_\_\_\_\_
- None

## Sleep

- Snoring
  - Sleepwalking
  - Nightmares
- Do you sleep well?  Yes  No
- Do you feel rested when you wake?  Yes  No
- Do you fall asleep during the day?  Yes  No