

# HEALTH HISTORY

(Confidential)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Age: \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical examination \_\_\_\_\_  
 What is your reason for today's visit? \_\_\_\_\_

**SYMPTOMS** Check (✓) symptoms you currently have or have had in the past year

**GENERAL**

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

**MUSCLE/JOINT/BONE**

Pain, weakness, numbness in:

- Arms       Hips
- Back       Legs
- Foot       Neck
- Hands       Shoulders

**GENITO-URINARY**

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

**GASTROINTESTINAL**

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

**CARDIOVASCULAR**

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

**EYE, EAR, NOSE, THROAT**

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - Flashes
- Vision - Halos

**SKIN**

- Bruises easily
- Hives
- Itching
- Changes in moles
- Rash
- Scars
- Sore that won't heal

**MEN only**

- Breast Lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other \_\_\_\_\_

**WOMEN only**

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other \_\_\_\_\_

Date of last menstrual  
 Period \_\_\_\_\_

Date of last Pap  
 Smear \_\_\_\_\_

Have you had a  
 Mammogram? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Number of children \_\_\_\_\_

**CONDITIONS** Check (✓) conditions you have or have had in the past

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts

- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes

- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio

- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempts
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

MEDICATIONS List medications you are currently taking	ALLERGIES to medications or substances

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

