# HEALTH HISTORY

Date: ___________________

**PATIENT:** ___________________________________________ **BIRTHDATE:** ___________________

LIST ANY MEDICATIONS YOU ARE ALLERGIC TO: __________________________________________

[ ] NONE KNOWN __________________________________________

LATEX ALLERGY? [ ] YES [ ] NO

CURRENT WEIGHT: ________________ SMOKER [ ] NON-SMOKER [ ]

DO YOU DRINK ALCOHOL? [ ] Not at all [ ] Daily [ ] Sometimes

DO YOU USE MARIJUANA, COCAINE, CRANK, HEROIN OR OTHER DRUGS?

[ ] Not at all [ ] Previously [ ] Daily [ ] Sometimes

IF NECESSARY, WOULD YOU ACCEPT A BLOOD TRANSFUSION? [ ] YES [ ] NO

DO YOU HAVE A PACEMAKER? [ ] YES [ ] NO

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PLEASE CHECK ANY OF THE SYMPTOMS YOU HAVE

[ ] Fatigue
[ ] Fever / Chills
[ ] Poor Appetite
[ ] Night Sweats
[ ] Weight Loss

[ ] Dizziness
[ ] Headaches
[ ] Temporary Numbness

[ ] Loss of Hearing
[ ] Sinus Problem
[ ] Difficulty Swallowing

[ ] Chest Pain
[ ] Rapid / Irregular Heartbeat
[ ] Swelling of Ankles

[ ] Persistent Cough
[ ] Shortness of Breath When Walking
[ ] Nighttime Shortness of Breath

[ ] Bleeding Gums
[ ] Nose Bleeds
[ ] Easy Bruising

[ ] Abdominal Pain
[ ] Bloating
[ ] Indigestion
[ ] Nausea
[ ] Vomiting
[ ] Vomiting Blood

[ ] Back Pain
[ ] Hip Pain
[ ] Groin Pain
[ ] Calf / Leg Pain

[ ] Blood in Urine
[ ] Painful Urination
[ ] Frequent Urination
[ ] Urination at Night
[ ] Lack of Bladder Control

[ ] Constipation
[ ] Diarrhea
[ ] Rectal Pain
[ ] Rectal Bleeding
[ ] Change in Stool Size
[ ] Black Stools

[ ] Breast / Chest Lump
[ ] Change in Size / Color of a Mole
[ ] A Sore That Won't Heal
[ ] Lump in Testicles / Scrotum

[ ] Wears Glasses / Contacts
[ ] Blurry Vision
[ ] Temporary Vision Loss

[ ] Memory Problem
[ ] Anxiety
[ ] Insomnia

## HEALTH HISTORY continued

PLEASE CHECK ANY PREVIOUS OR CURRENT MEDICAL PROBLEMS

[ ] Anemia
[ ] Arthritis
[ ] Asthma / Bronchitis / Emphysema
[ ] Bleeding / Blood Disorder
[ ] Cataracts
[ ] Diabetes
[ ] Epilepsy / Seizures
[ ] Gout
[ ] Hemorrhoids
[ ] Hard of Hearing / Deaf
[ ] Kidney Disease
[ ] Migraines
[ ] Pacemaker
[ ] Psychiatric Care: ______________________________
(*please specify)*
[ ] Stomach / Duodenal Ulcer
[ ] Tuberculosis
[ ] Venereal Disease
[ ] Autoimmune Disease
[ ] Liver Disease
[ ] Hernia: (type) _____________________
[ ] Stroke
[ ] Glaucoma
[ ] Heart Disease
[ ] Hepatitis: (type) ___________________
[ ] HIV Positive
[ ] Cancer: (type) _____________________
[ ] Hypertension / High Blood Pressure
[ ] Enlarged Prostate
[ ] Rheumatic Fever
[ ] Thyroid Problem: (type) _____________
[ ] Urinary Tract / Bladder Infection
[ ] Vaginal Infections
[ ] Varicose Veins
[ ] *Other:* ____________________________________________________________

Date of last colonoscopy: _________________________ Date of last pelvic exam: ______________________

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HAVE ANY OF THE FOLLOWING BLOOD RELATED RELATIVES HAD CANCER? [ ] No [ ] I don’t know

[ ] Mother (type) ______________________________ [ ] Father (type) ______________________________

[ ] Sister (type) _______________________________ [ ] Aunt (type) ______________________________

[ ] Brother (type) ______________________________ [ ] Uncle (type) ______________________________

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HAVE YOU EVER BEEN HOSPITALIZED OR HAD SURGERY? [ ] YES [ ] NO
*If you answered yes, please indicate in what year and for what reason.*

Year: _______________ Type: __________________________________________________________

Year: _______________ Type: __________________________________________________________

Year: _______________ Type: __________________________________________________________

Year: _______________ Type: __________________________________________________________

Year: _______________ Type: __________________________________________________________

*I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of her office responsible for any errors or omissions that I may have made in the completion of this form.*

Signed: ____________________________________________________ Date: ______________________

# CURRENT LIST OF MEDICATIONS

**PATIENT: ____________________________________ DATE: ___________________**

**Please indicate if you take any of the following on a daily/regular basis.**

- **[ ] Aspirin**
- **[ ] Ibuprofen Products (Advil, Motrin, Aleve)**
- **[ ] Acetaminophen Products (Tylenol)**
- **[ ] Vitamin E**
- **[ ] Over the counter antacids (Which ones? ____________)**

**Please list all medications (prescription & non-prescription) you take on a regular basis.**

| NAME OF DRUG | DOSAGE | TAKEN HOW OFTEN |
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**Have you taken any aspirin or ibuprofen products this week? [ ] yes [ ] no**

**-----------------------------------Below for staff use only---------------------------------**

**Verified as current on ___________________________ by _______________**

**Verified as current on ___________________________ by _______________**

**Verified as current on ___________________________ by _______________**

**Verified as current on ___________________________ by _______________**

**Verified as current on ___________________________ by _______________**

**Verified as current on ___________________________ by _______________**

**[ ] See new list dated ___________________________**