

**Health History**

**Date:**

Patient Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Internist \_\_\_\_\_ Phone No.: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

History of Present Illness: \_\_\_\_\_

Location: \_\_\_\_\_ Quality: \_\_\_\_\_  
(Example: Normal versus abnormal color, activity, etc.)

Severity: \_\_\_\_\_ Duration: \_\_\_\_\_  
(How severe is the pain/problem on a scale of 1 to 5 with 5 the most severe?) (How long have you had this pain/problem? Or, when did the pain/problem start?)

Timing: \_\_\_\_\_ Context: \_\_\_\_\_  
(Does the pain/problem occur at a specific time?) (What makes the pain/problem worse or better? Or, Have you had previous episodes?)

**LIST OF CURRENT MEDICATIONS AND DOSES: (IF YOU HAVE LIST, ATTACH)**

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES TO THE FOLLOWING MEDICATIONS:**

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE CIRCLE IF YOU HAVE/HAD ANY OF THE FOLLOWING:**

- |                                       |                                 |                       |                 |
|---------------------------------------|---------------------------------|-----------------------|-----------------|
| AIDS OR HIV+                          | BRONCHITIS                      |                       | PNEUMONIA       |
| ANEMIA                                | CANCER                          | HEPATITIS A or B or C | POLIO           |
| ARTHRITIS                             | DIABETES                        | HIGH BLOOD PRESSURE   | RHEUMATIC FEVER |
| ASTHMA                                | EPILEPSY                        | HIVES OR ECZEMA       | STROKE          |
| BACK TROUBLE                          | GLAUCOMA                        | KIDNEY DISEASE        | THYROID DISEASE |
| BLADDER INFECTION                     | HEART DISEASE                   | LOW BLOOD PRESSURE    | TUBERCULOSIS    |
| BLEEDING TENDENCY                     | HEMORRHOIDS                     | MITRAL VALVE PROLAPSE | ULCER           |
| BLOOD OR PLASMA TRANSFUSIONS          |                                 |                       |                 |
| ANY OTHER DISEASE(S)<br>(Please list) | DATE OF LAST CHEST X-RAY: _____ |                       |                 |

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES WHEN?

**Patient Social History**

Marital status: Single: \_\_\_ Married: \_\_\_ Separated: \_\_\_ Divorced: \_\_\_ Widowed: \_\_\_  
Use of Alcohol: Never: Rarely: Moderately: Daily:

Use of Tobacco: Never: Previously, but quit Current packs per day:  
Use of Drugs: Never: Type/Frequency:

**Family Medical History:**

Age	Diseases	If Deceased, Cause of Death
Father:		
Mother:		
Siblings:		

**REVIEW OF SYSTEMS:  
HEIGHT: WEIGHT: PULSE:**

Do you now or have you had any problems related to the following systems? **CIRCLE THE INDIVIDUAL ITEM IF YES:**

**Constitutional Symptoms**

Fever  
Chills  
Headaches  
Other:

**Integumentary**

Skin rash  
Boils  
Persistent Itch  
Other:

**Psychologic**

Are you generally satisfied with your life?  
Do you feel severely depressed?  
Have you considered suicide?  
Other:

**Eyes**

Pain  
Blurred or double vision  
Other

**Musculoskeletal**

Joint pain  
Neck Pain  
Back Pain  
Other

**Allergic/Immunologic**

Hay Fever  
Drug Allergies  
Other

**Ear/Nose/Throat/Mouth Cardiovascular**

Ear Infection  
Sore Throat  
Sinus Problem  
Other  
Chest Pain  
High Blood Pressure

**Neurological**

Tremors  
Dizzy Spells  
Numbness/Tingling  
Other

**Genitourinary**

Urine Retention  
Painful Urination  
Urinary Frequency  
Urinary Incontinence  
Other

**Gastrointestinal**

Abdominal Pain  
Nausea or vomiting  
Other

**Endocrine**

Excessive Thirst  
Too hot/cold  
Tired/Sluggish  
Other

**Respiratory**

Wheezing  
Frequent Cough  
Shortness of Breath  
Other

**Hematologic/Lymphatic**

Swollen Glands  
Blood Clotting Problems  
Other

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform necessary services I may need.

Date \_\_\_\_\_

Patient Signature

Physician Signature