



**HEALTH HISTORY**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Highest Education Level: \_\_\_\_\_

Regular Exercise you engage in: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Hobbies: \_\_\_\_\_  
\_\_\_\_\_

Medications (prescription and non-prescription), vitamins, herbs, supplements, etc, include dosages:

_____	_____
_____	_____
_____	_____

**Medication Allergies and the reaction:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Persistent Medical Problems- please list:

_____	_____
_____	_____
_____	_____

Hospitalizations/Surgeries-please list:

Date:	Reason/Event:
_____	_____
_____	_____

**Family History:**

	Age (or age at death)	Medical Conditions or cause of death
Father	_____	_____
Mother	_____	_____
Sister(s)	_____	_____
	_____	_____
Brother(s)	_____	_____
	_____	_____
	_____	_____

**Any Family History of:**

Yes	No		Yes	No	
___	___	Breast cancer	___	___	Heart Disease
___	___	Colon cancer	___	___	Depression/Anxiety
___	___	Prostate cancer	___	___	Other mental illness
___	___	High blood pressure	___	___	Alcoholism
___	___	Diabetes			

**Immunization History:**

When was your last tetanus shot? \_\_\_\_\_

**Health Risks:**

Yes	No	
___	___	Do you use tobacco? If yes, what kind and how much? _____
___	___	Do you use alcohol? If yes, how much/week? _____
___	___	If you ride a motorcycle or bicycle, do you wear a helmet?
___	___	If you ski or snowboard, do you wear a helmet?
___	___	Do you use seatbelts regularly?
___	___	Do you use sunscreen most of the time?
___	___	Does your home have a smoke alarm?

**Do you currently have any of the following symptoms or concerns?**

<b>Yes</b>	<b>No</b>	
___	___	Any eye problems?
___	___	Glaucoma or persistent eye pain?
___	___	Eye itching, burning, tearing
___	___	Double vision, blurred or decreased vision
___	___	Wear contact lenses or glasses?
___	___	Any hearing difficulties or other ear problems?
___	___	Any ringing in the ears?
___	___	Frequent nose bleeds?
___	___	Allergies with congestion, runny nose, etc.?
___	___	Any dental problems?
___	___	Voice changes or hoarseness
___	___	Recurrent throat problems
___	___	Any trouble breathing/ shortness of breath?
___	___	Chronic cough?
___	___	Asthma?
___	___	Coughing up blood?
___	___	Any heart problems?
___	___	Palpitations?
___	___	Do you get chest pain with activity?
___	___	Do you ever get racing heart or lightheaded with activity?
___	___	Ever exposed to tuberculosis or have positive skin test or chest x-ray?
___	___	Frequent swelling of the feet?
___	___	Ever had blood clots in the legs or lungs?
___	___	Ever had rheumatic fever?
___	___	Does walking cause pain in your legs?
___	___	Any skin problems?
___	___	Any suspicious lesions, discoloration or pigmentation changes?
___	___	Have you ever had a skin cancer removed?
___	___	Any difficulty or painful swallowing?
___	___	Frequent heartburn?
___	___	Any reflux symptoms?
___	___	Ever had an ulcer?
___	___	Any problems with nausea and vomiting?
___	___	Any problems with digestion or bowel movements?
___	___	Any black stools or bright red blood in the stools?
___	___	Any problems with urination?
___	___	Trouble emptying the bladder?
___	___	Leaking urine?

**Do you currently have any of the following symptoms or concerns?**

<b>Yes</b>	<b>No</b>	
___	___	Ever had a kidney stone?
___	___	Any arthritis or joint pain. If yes, where? _____
___	___	Recurrent back problems?
___	___	Other bone or joint problems?
___	___	Frequent headaches?
___	___	Migraine headaches?
___	___	Ever lost consciousness or had a seizure?
___	___	Any trouble sleeping?
___	___	Any difficulty concentrating?
___	___	Excessive worry or nervousness?
___	___	Are you worried you might have depression?
___	___	Any increased appetite, increased thirst and urination?
___	___	Any history of diabetes?
___	___	Do you bleed or bruise easily?
___	___	Any unexplained weight loss or gain in the past 12 months?
___	___	Any fever?
___	___	Any weakness or fatigue?
___	___	Any unusual heat or cold sensitivity?
___	___	Any significant appetite change or hair loss?
___	___	Ever had a thyroid problem?

**Questions for men only:**

<b>Yes</b>	<b>No</b>	
___	___	Any lumps or pain of the testicles?
___	___	Any questions about when or how to examine your testicles?

**Questions for women only:**

<b>Yes</b>	<b>No</b>	
___	___	Any chance you could be pregnant?
___	___	Last normal menstrual period: _____
___	___	Any lumps, pain, skin changes or discharge of the breast?
___	___	Any questions about when or how to examine your own breasts?
___	___	Any history of irregular menstruation or painful menstruation?
___	___	Any symptoms of peri-menopause (hot flashes, sleep difficulties, irritability, vaginal dryness)?
___	___	Are you menopausal?