



Health History Form

Name: _____ Date: _____ Birth date: _____

Chief Complaint: What is the reason for your visit today?

Drug or food allergies:

Medications including aspirin:

Previous Surgery : Please include the approximate year the surgery was performed.

Medical History: Please circle all that apply to you.

- | | | | | |
|----------------|---------------------|--------------|-----------|----------------|
| Diabetes | High blood pressure | Heart attack | Stroke | Thyroid |
| Heart Failure | Endometriosis | Chest pain | Ulcers | Kidney stones |
| Diverticulitis | Irregular heartbeat | Emphysema | Arthritis | Kidney failure |

Cancer (specify) _____

Other (specify) _____



Health History Form (cont.)

Family History: Please circle if any family members have had these problems.

Prostate cancer	Bladder cancer	Kidney cancer	Heart disease
High Blood pressure	Diabetes	Kidney disease	Kidney stones

Social History: Please circle.

Married	Yes	No			
Smoke	Yes	No	_____ packs per day for	___ years	
Alcohol	Yes	No	Occasional	Regular	_____ drinks per day

Have you had any of these problems recently?

Fever	Weight Loss	Chills
Blurry vision	Double vision	Cataracts
Hearing Loss	Nasal Stuffiness	Sore Throat
Chest Pains	Swollen Ankles	Irregular Heart Beat
Shortness of Breath	Wheezing	Chronic Cough
Incontinence	Painful Urination	Blood in Urine
Chronic Back Pain	Chronic Neck Pain	Sore Muscles
Rash	Persistent Itching	Skin Cancer History
Numbness	Tingling	Dizziness
Swollen Glands	Abnormal Bleeding	Transfusion History

