

HEALTH HISTORY

Name: _____ Birth Date: _____ Age: _____

Reason for Today's Visit: _____

Referring Doctor: _____ Primary Care Doctor: _____

Medications: List dose or number of pills per day.

Prescription Drugs: _____

Non Prescription Drugs: (Vitamins, Herbs) _____

Regular Aspirin Use: _____no _____yes

Dosage & Frequency: _____

NSA (Advil, Motrin, Ibuprofen): _____no _____yes

Dosage & Frequency: _____

Drug Allergy: _____no _____yes List Drug(s) and type of reaction: _____

List previous operations or major illnesses and dates: _____

Family History

Has any blood relative ever had the following:

Breast Cancer.....	no	yes	High blood pressure.....	no	yes	Kidney disease.....	no	yes
Melanoma	no	yes	Heart Disease	no	yes	Depression.....	no	yes
Stroke	no	yes	Diabetes	no	yes			

Past Medical History

Have you ever had the following:

Heart disease	no	yes	Cancer	no	yes	Stomach Ulcer	no	yes
Arthritis	no	yes	Glaucoma	no	yes	Kidney disease	no	yes
Rheumatic Fever	no	yes	Asthma	no	yes	Thyroid Disease	no	yes
Anemia	no	yes	AIDS or HIV+	no	yes	Tuberculosis	no	yes
Stroke.....	no	yes	Mitral Valve Prolapse... ..	no	yes	High Blood Pressure	no	yes
Diabetes	no	yes	Hepatitis	no	yes			

Review of Systems

Do you have now or have you had within the past year:

Weight change	no	yes	Swollen feet/ ankles	no	yes	Seizures	no	yes
Dry eyes	no	yes	Skin rash	no	yes	Joint or muscle pain ...	no	yes
Chronic cough	no	yes	Chronic diarrhea	no	yes	Swollen lymph nodes ...	no	yes
Chest pain	no	yes	Jaundice	no	yes	Easy bleeding	no	yes
Rapid heart beat	no	yes	Depression	no	yes	Easy bruising	no	yes

Do you Smoke? _____no _____yes How Much? _____ Do you drink alcohol? _____no _____yes How much? _____

Have you ever had Local anesthesia? _____no _____yes Occupation: _____

Women only:

Number of Children _____ Number of pregnancies _____ Did you breast feed? no yes Age Menstrual period began _____

Are you pregnant? no yes Date of last mammogram _____ Breast lump or discharge no yes

Do you do regular breast-examinations? _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____
Signature of patient or parent if minor

Date

Physician's Signature _____ Date _____

Name: _____ BithDate: _____ Age: _____

Completed By Physician

Physical Exam

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Temp: _____ Respirations: _____

General Status Comment

HEENT: _____

Vision: _____

Pulmonary: _____

CV: _____

Abdomen: _____

Extremity: _____

Skin: _____

Comments:
