

HEALTH HISTORY

Name _____ Age _____ Today's Date _____
Birth Date _____ Date of last physical examination _____ Primary Care Dr. _____

I. Check the problem(s) which bring you to our office:

- Anaphylaxis (shock) Asthma Ear problems Eczema Eye problems Food Allergy
- Hives Polyps Rhinitis ("Hay fever") Serum sickness Sinusitis (sinus infections)
- Stinging Insect Allergy Swelling Other _____

II. MEDICATIONS (List medications you are currently taking, including all over the counter and supplements): _____

III. ALLERGIES (To medications or substances): _____

IV. SYMPTOMS (Check symptoms you currently have or have had in the past year):

GENERAL

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Nervousness
- Numbness
- Sweats
- Weight loss

SKIN

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

GASTROINTESTINAL

- Appetite poor
- Bloating
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

WOMEN ONLY

Are you pregnant? Yes No

EYE/ EAR/ NOSE/ THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – flashes
- Vision – halos

MUSCLE/JOINT/BONE

- Pain, weakness, numbness in:
- Arms Hips
 - Back Legs
 - Feet Neck
 - Hands Shoulder

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

V. CONDITIONS (Check conditions you have or have had in the past):

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Ear infections
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High blood pressure
- High cholesterol
- HIV positive
- Hives
- Kidney disease
- Liver disease
- Lupus
- Measles
- Migraine headaches
- Miscarriage
- Mononucleosis
- Mumps
- Pacemaker
- Pneumonia
- Polio
- Prostate problem
- Psychiatric care
- Recurrent upper respiratory tract infections
- Recurrent sinus infections
- Rheumatic fever
- Scarlet fever
- Skin rashes
- Stroke
- Suicide attempt
- Thyroid problems
- Tonsillitis
- Tuberculosis
- Typhoid fever
- Ulcers
- Vaginal infections
- Venereal disease

VI. FAMILY HISTORY

Fill in health information about your family:

Relation	Age	State of health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relative had any of the following: Disease Relationship to you	
<input type="checkbox"/>	Asthma, hay fever
<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Chemical dependency
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	Lupus/Rheumatoid Arthritis
<input type="checkbox"/>	Pulmonary (lung) Disease
<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Other
<input type="checkbox"/>	

VII. HOSPITALIZATIONS/SURGERIES

Year	Reason for hospitalization or surgery

VIII. PATIENT SOCIAL HISTORY:

- Marital status: Single Married Separated Divorced Widowed
- Use of alcohol: Never Rarely Moderate Daily
- Use of tobacco: Never Previously, but quit Current, packs/day _____
- Use of drugs: Never Type/ Frequency _____
- Excessive exposure at home, work or school to: Fumes Dust Solvents Airborne particles Smoke
- Your occupation: _____

IX. ENVIRONMENTAL HISTORY:

- Age of your home: _____ How long have you lived there? _____
- Your home is a(n): Apartment Townhouse Detached home
- Heat at home is (check all that apply): Forced warm air (central heating) Radiator (steam/hot water)
 Electric baseboard Wood stove
- Air conditioning at home: None Central Window units _____ Bedroom _____ Living room/family room
- Humidifier at home: None Central (furnace) Room unit, location _____
- Air cleaner/purifier at home: None Central (furnace) Room unit, location _____
- Type of mattress on the patient's bed: Regular Air mattress Waterbed Other _____
Age of mattress _____
- Dust mite covers? Yes No If yes, they are on Mattress Box Springs Pillows Comforters
- Type of pillow on the patient's bed: Foam/ fiber-filled Feather Other _____
Age of pillow _____
- Type of comforter on the patient's bed: Down-filled Polyester fill Cotton fill Other
- Carpeting: In the home: Wall to wall Area rug None
 Patient's bedroom: Wall to wall Area rug None
- What fur-bearing pets do you have? None Cat(s) Dog(s) Other _____
- Do you have feathered pets? No Yes
- Do these pets have access to the patient's bedroom? Never Sometimes Often