

Date _____

Name _____ Birthdate _____

Age _____ Sex _____ Race _____

HEALTH HISTORY OF THE PATIENT

FAMILY HISTORY

REVIEW OF SYSTEMS

	YES	NO
Asthma	()	()
Stroke	()	()
Heart Trouble	()	()
High Blood Pressure	()	()
Diabetes	()	()
Arthritis	()	()
Gout	()	()
Seizures	()	()
Mental Illness	()	()
Kidney Trouble/Stones	()	()
Cancer	()	()
Bleeding Disorders	()	()
Alcoholism	()	()
Serious Injuries	()	()
Lung Disease	()	()
Tuberculosis	()	()
Phlebitis	()	()
Anemia	()	()
Stomach Ulcers	()	()
Liver Trouble	()	()
Thyroid Trouble	()	()
Other Illnesses	()	()

	YES	NO
Stroke	()	()
Heart Trouble	()	()
High Blood Pressure	()	()
Diabetes	()	()
Arthritis	()	()
Gout	()	()
Seizures	()	()
Mental Illness	()	()
Kidney Trouble/Stones	()	()
Cancer	()	()
Bleeding Disorders	()	()
Alcoholism	()	()
Other	()	()

Have you recently had or do you now have:

	YES	NO
Reading Glasses	()	()
Change of Vision	()	()
Loss of Hearing	()	()
Ear Pain	()	()
Hoarseness	()	()
Nose Bleeds	()	()
Difficulty Swallowing	()	()
Morning Cough	()	()
Shortness of Breath	()	()
Chills or Fever	()	()
Heart or Chest Pain	()	()
Abnormal Heartbeat	()	()
Badly Swollen Ankles	()	()
Calf Cramps with Walking	()	()
Poor Appetite	()	()
Toothache	()	()
Gum Trouble	()	()
Nausea or Vomiting	()	()
Stomach Pain	()	()
Ulcers	()	()
Frequent Belching	()	()
Frequent Loose Bowel Move.	()	()
Blood in Bowel Movement	()	()
Frequent Constipation	()	()
Hemorrhoids	()	()
Frequent Urination (pass water)	()	()
Burning on Urination	()	()
Difficulty starting Urination	()	()
Difficulty stopping Urination	()	()
Get up every night to Urinate	()	()
Frequent Rash	()	()
Hot or Cold Spells	()	()
Recent Weight Change	()	()
Nervous Exhaustion	()	()
Insomnia	()	()
Depression	()	()
Nervous Tension	()	()

Explain all yes answers:

Explain all yes answers:

Cause of death of parents, brothers, sisters:

SOCIAL HISTORY

Surgical Procedures (include dates)

Most Recent Occupation

Married () Single ()

Widowed () Divorced ()

Current Medications / Dosages

Number of Pregnancies _____

Number of Children Living _____

Presently living alone?

Yes () No ()

Allergies to Medications None ()

Smoke _____ packs per day

Alcohol: Never () Occasional ()
Moderate to Heavy ()

Drug overuse: None ()
Presently ()
Past Problem ()

Women Only!

Irregular Periods	()	()
Vaginal Discharge	()	()
Frequent Spotting	()	()