



Health History Form

Name: _____ Date: _____

Address: _____ Telephone Daytime: _____

_____ Telephone Evening: _____

Gender: _____ Date of Birth: _____ Email: _____

Medicaid/Insurance Policy # _____

Please check (✓) only those items that apply, and provide more specifics as appropriate.

GENERAL

Weight gain or loss _____

Fatigue _____

SKIN

Rash _____

Sore that won't heal _____

Other _____

HEAD/EYES/EARS/NOSE/THROAT

Headaches _____

Dizziness _____

Ringing in ears _____

Vision Changes _____

Persistent runny or bloody nose _____

Sinus problems _____

Problems with teeth/gums _____

Difficulty chewing or swallowing _____

Sores in mouth _____

Other _____

CHEST

Heart problems _____

Chest pain _____

Palpitations _____

Lung problems _____

Shortness of breath _____

Cough _____

Asthma _____

NEUROLOGIC

Numbness or tingling _____
Weakness of arm or leg _____
Problems with memory _____

ABDOMEN

Heartburn _____
Abdominal pain _____
Gas _____
Diarrhea _____
Constipation _____
Blood in stool _____
Swelling or bloating _____
History of
 Ulcers _____
 Diverticulitis _____
 Colitis _____
 Hepatitis _____
Change in bowel habits _____

URINARY SYSTEM

Kidney problems _____
Frequent urination at night _____
Pain with urination _____
Blood in urine _____
Difficulty starting urination _____
Difficulty stopping urination _____
Discharge _____

FEMALE

Date of last period _____
Problems with periods _____
Pain _____
Irregular periods _____
Excessive bleeding _____
Birth control type _____
Number of Pregnancies _____
Breast tenderness _____

MALE

Prostate problems _____
Scrotal pain _____
Scrotal mass _____

BONES & JOINTS

Arthritis _____
Swollen joints _____
Gout _____
Broken bones _____
Osteoporosis _____
Muscle problems _____
Swelling in feet/ankles _____

PSYCHOLOGICAL

Depression _____
Anxiety _____
Stress level: Low___ Medium___ High___
Sleep problems _____

SOCIAL

Type of job _____
Enjoy your work? _____
Are you (*circle one*)
Single Married Divorced Partner
Widow Widower SameSexPartner
Number of children _____
Ages _____
How much do you use?
Tobacco- smoke or chew _____
Illicit Drugs _____
Pets _____
Recent foreign travel _____
Exercise _____

MEDICAL CONDITIONS

Diabetes? _____
Hypertension? _____
Heart disease? _____
Cancer? _____
Other _____

Surgeries

Dates

_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Diabetes _____
Hypertension _____
Cancer; what types? _____
Tuberculosis _____
Alzheimer's Disease _____
Heart Problems _____
Arthritis _____
Other _____

ALLERGIES and SENSITIVITIES

Medications _____
Food _____
Animals _____
Plants _____
Other _____

IMMUNIZATIONS **Dates**
Tetanus _____
Pneumonia (Pneumovax) _____
Flu vaccine _____
Other _____

DATES OF MEDICAL TREATMENT
Pap Smear _____
Mammogram _____
Rectal exam _____
Cholesterol _____
EKG _____
Bone Density test _____
Thyroid test _____
Test for blood in stool _____
Colonoscopy/sigmoidoscopy _____

MEDICATIONS with dosages (*include vitamins, over the counter medications and food supplements*)

Any other special circumstances or medical conditions that were not been mentioned above?

