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Health History

Name: _____ DOB: _____ Age: _____
Date of Last Physical: _____ Reason for Visit: _____

Symptoms (check symptoms you currently have or have had in the past 12 months)

<p>General:</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <p>Muscle/Joint/Bone (Pain, weakness, numbness)</p> <input type="checkbox"/> Arms <input type="checkbox"/> Back <input type="checkbox"/> Feet <input type="checkbox"/> Hants <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Neck <input type="checkbox"/> Shoulders <p>Urinary</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination	<p>Gastroenterology</p> <input type="checkbox"/> Poor appetite <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <p>Cardiovascular</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Hypertension <input type="checkbox"/> Hypotension <input type="checkbox"/> Murmur <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p>Eye, Ear, Nose, Throat</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision – flashes <input type="checkbox"/> Vision – halos <p>Skin</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in Moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sores that won't heal	<p>MEN Only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulty <input type="checkbox"/> Testicular lump <input type="checkbox"/> Penile discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other <p>WOMEN only</p> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Severe menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other <p>Date of last menstruation: _____</p> <p>Date of last pap smear: _____</p> <p>Have you ever had a mammogram: _____</p> <p>Are you pregnant? _____</p> <p>Number of living children: _____</p>
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Conditions (check conditions you have or have had in the past twelve months)

<input type="checkbox"/> Aids <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Breast lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High cholesterol <input type="checkbox"/> HIV+ <input type="checkbox"/> Kidney disease <input type="checkbox"/> Liver disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraines <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate problems <input type="checkbox"/> Psychiatric care <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal infections <input type="checkbox"/> Venereal disease
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