Blossomwood Medical
primary care for adults

HEALTH HISTORY

Name: _____ DOB: _____ Age: _____

Date of Last Physical: _____ Reason for Visit: _____

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

General:
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Loss of weight
Nervousness
Sweats

Muscle/Joint/Bone:
Arms
Back
Feet
Hands
Hips
Legs
Neck
Shoulders

Skin:
Bruise easily
Hives
Itching
Changes in Moles
Rash
Scars
Sores that won't heal

Gastroenterology:
Poor appetite
Bloating
Bowel changes
Constipation
Diarrhea
Excessive hunger
Gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach pain
Vomiting
Vomiting blood

Cardiovascular:
Chest pain
Hypertension
Hypotension
Murmur
Poor circulation
Rapid heartbeat
Swelling of ankles
Varicose veins

Urinary:
Blood in urine
Frequent urination
Lack of bladder control
Painful urination
Incomplete emptying of bladder

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

MEN ONLY:
Breast lump
Erection difficulty
Testicular lump
Penile discharge
Sore on penis

Date of last prostate exam:
_____

Women Only:
Abnormal PAP Smear
Bleeding between Periods
Breast lump
Severe menstrual pain
Hot flashes
Nipple discharge
Painful intercourse
Vaginal discharge

Date of last menstruation:
_____

Date of last PAP smear:
_____

Date of last mammogram:
_____

Are you pregnant?
_____

Number of children:
_____

Conditions (circle conditions you have or have had in the past 12 months)

Aids
Alcoholism
Anemia
Anorexia
Arthritis
Asthma
Bleeding disorder
Breast lump
Bronchitis
Bulimia
Cancer _____

Chemical dependency
Diabetes
Emphysema
Epilepsy
Goiter
Gonorrhea
Gout
Heart disease
Hepatitis
Hernia
Herpes

High cholesterol
HIV+
Kidney disease
Liver disease
Migraines
Miscarriage
Mononucleosis
Pacemaker
Pneumonia
Prostate problems
Psychiatric care

Stroke
Suicide attempt
Thyroid problems
Tuberculosis
Ulcers
Vaginal infections
Venereal disease

COVID-19
Positive / Negative

Family History (Complete as much as you can)

Circle if any BLOOD relative have ever had the following and please specify whom:

Alcohol Dependence _____

Arthritis _____

Asthma _____

Cancer (what type for each person) _____

Chemical Dependence _____

Diabetes _____

Heart Disease _____

Hypertension _____

Kidney Disease _____

Stroke _____

Thyroid Disease _____

Tuberculosis _____

Other _____

Personal Medical History (Circle "Y" for yes or "N" for no)

1. Do you regard your work as stressful?	Y	N
2. Do you regard you home life as tense?	Y	N
3. Do you have trouble sleeping?	Y	N
4. Do you "blow up" at others often?	Y	N
5. Do you become stressed easily?	Y	N
6. Are you frequently irritable?	Y	N
7. Do you exercise at all? If yes, how often? _____	Y	N
8. Have you ever been treated by a Pain Management physician? If yes, whom did you see? _____	Y	N
9. Are you currently taking Suboxone or Methadone? If so, whom do you see? _____	Y	N

Surgeries (Please list what kind, date, and the surgeon that performed it?

1. What kind? _____ Date? _____ Surgeon? _____
2. What kind? _____ Date? _____ Surgeon? _____
3. What kind? _____ Date? _____ Surgeon? _____
4. What kind? _____ Date? _____ Surgeon? _____
5. What kind? _____ Date? _____ Surgeon? _____

Occupational Concerns (Circle all that you are exposed to at work?)	**Health Habits (Please circle all that apply. Note how much you use and begin date.**		
Stress / Hazardous Substance / Heavy Lifting / Other (please specify) _____ What is your occupation? _____	Caffeine	Tobacco	Alcohol

I certify that the above information is correct to the best of my knowledge. I will not hold any member of the Blossomwood Medical staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature **Date**