HEALTH HISTORY

Date: _____

Patient Name _____ Date of Birth _____ Sex: F or M

Height: _____ Weight: _____

Diagnosis:

Location: _____
(Where is the pain/problem?)

Duration: _____
(How long have you had this pain/problem?

Severity: _____
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Occurrence: _____
(Does the pain/problem occur at a specific time?)

Associated signs/symptoms: _____
(What other associated problems have you been having?)

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

AIDS or HIV+	no	yes	Date of last chest x-ray _____			Kidney Disease	no	yes	Smallpox	no	yes
Anemia	no	yes	Diabetes	no	yes	Liver Disease	no	yes	Stroke	no	yes
Arthritis	no	yes	Diphtheria	no	yes	Low Blood Pressure	no	yes	Thyroid Disease	no	yes
Asthma	no	yes	Epilepsy	no	yes	Measles	no	yes	Tuberculosis	no	yes
Back trouble	no	yes	Glaucoma	no	yes	Migraine Headaches	no	yes	Ulcer	no	yes
Bladder infections	no	yes	Heart Disease	no	yes	Mitral Valve Prolapse	no	yes	Venereal Disease	no	yes
Bleeding Tendency	no	yes	Hemorrhoids	no	yes	Mumps	no	yes	Whooping Cough	no	yes
Blood or Plasma			Hepatitis	no	yes	Phneumatic Fever	no	yes	Any other disease	no	yes
Transfusions	no	yes	Hernia	no	yes	Pneumonia	no	yes	(please list): _____		
Bronchitis	no	yes	High Blood Pressure	no	yes	Polio	no	yes			
Cancer	no	yes	Hives or Eczema	no	yes	Scarlet Fever	no	yes			
Chickenpox	no	yes	Infectious Mono	no	yes	Shingles	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications: (Include dose & frequency, over the counter medications and/or supplements)

_____

_____

_____

_____

_____

_____

_____

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 recreational drugs: Never: _____ Type/Frequency: _____ _____

Excessive exposure At home or work to: Fumes:_____ Dust: _____ Solvents:_____ Airborne Particles: _____ Radiation _____

Family medical history:

	Age	Disease/Diagnosis	If Deceased, cause of Death & When
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____