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Patient Health History

PATIENT NAME: _____BIRTHDATE:_____ Age: __ Sex: __

PRIMARY CARE PHYSICIAN: _____ Height_____ Weight_____

Current Problem: _____

Past Medical History (list of medical diagnoses, example hypertension, kidney stones):

___Hypertension ___Cholesterol ___Stroke ___Emphysema
___Heart Attack ___Sleep Apnea ___Diabetes ___Other_____

_____

_____

_____

Past Surgical History (please list all surgeries including approximate date or year):

CURRENT MEDICATIONS & DOSAGES (Includes ASPIRIN and prescriptions, birth control, and non-prescription & supplements)

_____ NONE _____ see separate list I have provided

_____

_____

_____

_____

ALLERGIES AND REACTION: _____ No known allergies

Sulfa_____ Penicillin ____Aspirin _____ Any Anesthesia Related Drug_____

Morphine ____Codeine ___ Latex_____ _Other (name) _____

DESCRIBE THE REACTION:

HABITS

TOBACCO: □ NO □ YES FORM /AMOUNT USED: _____ # YRS. USED_____ DATE STOPPED_____

ALCOHOL: □ NO □ YES FORM /AMOUNT USED: _____ # YRS. USED_____ DATE STOPPED _____

MARIJUANA: □ NO □ YES METHAMPHETAMINE: □ NO □ YES COCAINE □ NO □ YES HEROINE □ NO □ YES

_____

DAILY ACTIVITIES

OCCUPATION: _____ working _____retired _____ not employed _____ student
DESCRIBE YOUR EXERCISE ACTIVITIES: _____

_____

Number of times per week: _____

RELIGION: (optional) Would you accept a blood transfusion?

_____

FAMILY HEALTH HISTORY ____ **No History of Familial Disease**

Blood Relation (Mother, Father, siblings etc)	**Illness (i.e.: Cancer, Heart, Diabetes)**

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

CONDITION	***Y***	***N***	***Date/Yr***	***CONDITION***	***Y***	***N***	***Date /Yr***
GENERAL/CONSTITUTIONAL				**GENITOURINARY**			
Change in appetite				Urinary urgency			
Weight gain				Night-time urination			
Weight loss				Frequent urination			
Night sweats				Burning or pain on urination			
Fever				Reduced stream			
Chills				Blood in urine			
Weakness				Vaginal discharge			
HEENT				**MUSCULOSKELETAL**			
Vision problems				Joint pain			
Ear problems				Muscle pain			
Sinus problems				Muscle weakness			
Nose bleeds				Neck pain			
Difficulty swallowing				Back pain			
CARDIOVASCULAR				Difficulty walking			
Chest pain				**INTEGUMENTARY**			
Chest pressure/discomfort				Bruising			
Heart murmur				Itching			
Palpitations				Sores			
Swelling				Rash			
Difficulty breathing while laying down				**NEUROLOGICAL**			
RESPIRATORY				Headaches			
Difficulty breathing				Migraines			
Wheezing				Seizures			
Chest Congestion				Short term memory problems			
Cough				Long term memory problems			
Phlegm				Weakness/numbness in arm			
				Losing control of urine/bowel			
PSYCHIATRIC				Cold intolerance			
Anxiety				Heat intolerance			

Depression							
Hallucinations				Hair loss			
Stress				**HEMATOLOGIC/LYMPHATIC**			
Bipolar disorder				Easy bleeding or bruising			
Schizophrenia				Anemia			
ENDOCRINE				Swollen glands			
Excessive appetite				Deep venous thrombosis			
Excessive sweating				Bleeding disorder			
Excessive thirst							
Excessive urination							

Please date and initial here after completing/reviewing/updating of your health history:

_____ _____ _____