

# HEALTH HISTORY

Confidential

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

**SYMPTOMS** Check (✓) symptoms you currently have or have had in the past year.

<p><b>GENERAL</b></p> <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> <p><b>MUSCLE/JOINT/BONE</b>                  Pain, weakness, numbness in:  <input type="checkbox"/> Arms      <input type="checkbox"/> Hips  <input type="checkbox"/> Back      <input type="checkbox"/> Legs  <input type="checkbox"/> Feet      <input type="checkbox"/> Neck  <input type="checkbox"/> Hands      <input type="checkbox"/> Shoulders</p> <p><b>GENITO-URINARY</b></p> <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>	<p><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> Appetite poor  <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> <p><b>CARDIOVASCULAR</b></p> <p><input type="checkbox"/> Chest pain  <input type="checkbox"/> High blood pressure  <input type="checkbox"/> Irregular heart beat  <input type="checkbox"/> Low blood pressure  <input type="checkbox"/> Poor circulation  <input type="checkbox"/> Rapid heart beat  <input type="checkbox"/> Swelling of ankles  <input type="checkbox"/> Varicose veins</p>	<p><b>EYE, EAR, NOSE, THROAT</b></p> <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> <p><b>SKIN</b></p> <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"/> Sore that won't heal</p>	<p><b>MEN only</b></p> <p><input type="checkbox"/> Breast lump  <input type="checkbox"/> Erection difficulties  <input type="checkbox"/> Lump in testicles  <input type="checkbox"/> Penis discharge  <input type="checkbox"/> Sore on penis  <input type="checkbox"/> Other</p> <p><b>WOMEN only</b></p> <p><input type="checkbox"/> Abnormal Pap Smear  <input type="checkbox"/> Bleeding between periods  <input type="checkbox"/> Breast lump  <input type="checkbox"/> Extreme 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> <p>Date of last menstrual period _____                  Date of last Pap Smear _____                  Have you had a mammogram? _____                  Are you pregnant? _____                  Number of children _____</p>
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**CONDITIONS** Check (✓) conditions you have or have had in the past.

<p><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 Disorders  <input type="checkbox"/> Breast Lump  <input type="checkbox"/> Bronchitis  <input type="checkbox"/> Bulimia  <input type="checkbox"/> Cancer  <input type="checkbox"/> Cataracts</p>	<p><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</p>	<p><input type="checkbox"/> High Cholesterol  <input type="checkbox"/> HIV Positive  <input type="checkbox"/> Kidney Disease  <input type="checkbox"/> Liver Disease  <input type="checkbox"/> Measles  <input type="checkbox"/> Migraine Headaches  <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</p>	<p><input type="checkbox"/> Prostate Problem  <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</p>
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**MEDICATIONS** List medications you are currently taking.

**ALLERGIES** To medications or substances

Pharmacy Name _____ Phone _____	
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