PATIENT HISTORY INFORMATION

Patients Full Name: **Date of Birth:**

Address:

City: **State:** **Zip:**

If minor, mother and father name:

How long at present address? **Phone no.**

____Male ____Female ____Married ____Single ____ Divorced ____Widowed

Number of children: **Social Security Number:**

Employer: **How long?**

Address: **Work Phone:**

Previous Employer:

Address:

Bank Name:

Address:

Person responsible for payment:

Address:

Name of Spouse:

Employer:

Address: **Work Phone:**

Referred by:

EMERGENCY CONTACT:

EMERGENCY PHONE:

INSURANCE:

*** PAYMENTS - CO PAYMENTS ARE DUE AT THE TIME OF SERVICE ***

Visa and MasterCard are accepted

CONFIDENTIAL HEALTH HISTORY

NAME: **DATE:**

BIRTHDATE: **AGE:** **SEX:**

GENERAL
___Chills
___Depression
___Dizziness
___Fainting
___Fever
___Forgetfulness
___Headache
___Loss of sleep
___Loss of weight
___Nervousness
___Sweats

JOINTS/MUSCLES
Pain, weakness, or numbness
___Arms ___Hips
___Back ___Legs
___Feet ___Neck
___Hands
___Shoulders

GENITO-URINARY
___ Blood in urine
___ Frequent urination
___ Lack of bladder control
___ Painful urination

GASTROINTESTINAL
___Poor appetite
___Bloating
___Bowel changes
___Diarrhea
___Excessive hunger
___Excessive thirst
___Gas
___Hemorrhoids
___Indigestion
___Nausea
___Rectal bleeding
___Stomach pain
___Vomiting
___Vomiting blood
___Colonoscopy

CARDIOVASCULAR
___Chest pain
___High blood pressure
___Irregular heart beat
___Low blood pressure
___Poor circulation
___Rapid heart beat
___Swelling in the ankles
___Varicose veins

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 the ears
___Sinus problems
___Vision – Flashes

SKIN
___Bruise easily
___Hives
___Itching
___Changes in moles
___Rash
___Scars
___Sores that won't heal
___Other

MEN ONLY
___Breast lump
___Erection difficulties
___Lump in testicles
___Penis discharge
___Sore on penis
___Other

WOMEN ONLY
___Abnormal pap smear
___Bleeding between period
___Breast lump
___Extreme menstrual pain
___Hot flashes
___Nipple discharge
___Painful intercourse
___Vaginal discharge
___Other

Last period_____
Last pap smear_____
Last mammogram_____
Are you pregnant?_____
Number of children_____

CONDITIONS Check conditions you have had or have had in the past.

☐ AIDS	☐ Chemical dependency	☐ High cholesterol	☐ Prostate problems
☐ Alcoholism	☐ Chicken pox	☐ HIV positive	☐ Psychiatric care
☐ Anemia	☐ Diabetes	☐ Kidney disease	☐ Rheumatic fever
☐ Anorexia	☐ Emphysema – COPD	☐ Liver disease	☐ Scarlet fever
☐ Appendicitis	☐ Epilepsy	☐ Measles	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Migraine headache	☐ Suicide attempt
☐ Asthma	☐ Goiter	☐ Miscarriage	☐ Thyroid problems
☐ Bleeding disorders	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis
☐ Breast lump	☐ Gout	☐ Multiple sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Heart disease	☐ Mumps	☐ Typhoid fever
☐ Bulimia	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hernia	☐ Pneumonia	☐ Vaginal infections
☐ Cataracts	☐ Herpes	☐ Polio	☐ Venereal disease

MEDICATIONS List medicines and doses you are taking.	**ALLERGIES to medicine.**

Please complete the other side of this form →

FAMILY HISTORY Please fill in health information about your family

Relation	Age	Health	Age at death	Cause of death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of the following.

	Disease	Relationship
	Arthritis	
	Asthma	
	Cancer	
	Chemical dependency	
	Diabetes	
	Heart disease, stroke	
	High blood pressure	
	Kidney disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS AND SURGERIES

Year	Hospital	Reason and Outcome

PREGNANCY HISTORY

Year	Sex	Complications?

HEALTH HABITS

Check which you use and amounts

	Caffeine	
	Tobacco	
	Alcohol	
	Drugs	
	Other	

Have you ever had a blood transfusion? ☐Yes ☐No

If yes, please give dates.

Illness or injuries	Date	Outcome

OCCUPATIONAL

Any exposed to the following?

	Stress
	Hazardous substances
	Heavy lifting
	Other

Your occupation:

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

Signature of patient or guardian: Date: