## **CONFIDENTIAL HEALTH HISTORY**

Name:			_ Date:
Birthdate:	Age: [	Date of last physical exami	nation:
Occupation:			
Reason for visit today:			
MEDICATIONS List all med	lications you are currently taking	g ALLERGIE	S List all allergies
SYMPTOMS Check ( ) s	ymptoms you currently have or	have had in the past year.	
GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN only
☐ Chills	☐ Appetite poor	☐ Bleeding gums	☐ Breast lump
☐ Depression	☐ Bloating	☐ Blurred vision	☐ Erection difficulties
☐ Dizziness	☐ Bowel changes	☐ Crossed eyes	☐ Lump in testicles
$\square$ Fainting	☐ Constipation	☐ Difficulty swallowing	<ul><li>Penis discharge</li></ul>
☐ Fever	Diarrhea	☐ Double vision	☐ Sore on penis
☐ Forgetfulness	Excessive thirst	☐ Earache	☐ Other
☐ Headache	☐ Gas	☐ Ear discharge	WOMEN only
☐ Loss of sleep	Hemorrhoids	☐ Hay fever	☐ Abnormal Pap Smear
<ul><li>☐ Loss of weight</li><li>☐ Nervousness</li></ul>	Indigestion	☐ Hoarseness	□ Bleeding between periods
☐ Numbness	☐ Nausea	<ul><li>☐ Loss of hearing</li><li>☐ Nosebleeds</li></ul>	☐ Breast lump
☐ Sweats	☐ Rectal bleeding	☐ Persistent cough	Extreme menstrual pain
	☐ Stomach pain	☐ Ringing in ears	☐ Hot flashes
MUSCLE/JOINT/BONE Pain, weakness, numbness in:	☐ Vomiting	☐ Sinus problems	☐ Nipple discharge
	☐ Vomiting blood	☐ Vision - Flashes	☐ Painful intercourse
☐ Arms ☐ Hips ☐ Back ☐ Legs	CARDIOVASCULAR	☐ Vision - Halos	<ul><li>☐ Vaginal discharge</li><li>☐ Other</li></ul>
☐ Feet ☐ Neck	☐ Chest pain	SKIN	Date of last
☐ Hands ☐ Shoulders	☐ High blood pressure	☐ Bruise easily	menstrual period
	☐ Irregular heart beat	☐ Hives	Date of last
GENITO-URINARY	☐ Low blood pressure	☐ Itching	Pap Smear
☐ Blood in urine	☐ Poor circulation	☐ Change in moles	Have you had
<ul><li>☐ Frequent urination</li><li>☐ Lack of bladder control</li></ul>	☐ Rapid heart beat	☐ Rash	a mammogram?
Painful urination	☐ Swelling of ankles	☐ Scars	Are you pregnant?
T difficilities	☐ Varicose veins	☐ Sores that won't heal	Number of children
MEDICAL HISTORY Che	eck ( 🖊 ) the medical condition	ns you have or have had in the p	
☐ AIDS	☐ Chemical Dependency	☐ Herpes	☐ Polio
☐ Alcoholism	☐ Chicken Pox	☐ High Cholesterol	☐ Prostate Problem
☐ Anemia	☐ Diabetes	☐ HIV Positive	☐ Psychiatric Care
<ul><li>☐ Anorexia</li><li>☐ Appendicitis</li></ul>	<ul><li>☐ Emphysema</li><li>☐ Epilepsy</li></ul>	<ul><li>☐ Kidney Disease</li><li>☐ Liver Disease</li></ul>	<ul><li>☐ Rheumatic Fever</li><li>☐ Scarlet Fever</li></ul>
☐ Appendicitis ☐ Arthritis	<ul><li>☐ Epilepsy</li><li>☐ Gall Bladder Disease</li></ul>	☐ Measles	☐ Stroke
☐ Asthma	☐ Glaucoma	<ul><li>☐ Migraine Headaches</li></ul>	☐ Suicide Attempt
☐ Bleeding Disorders	☐ Goiter	☐ Miscarriage	☐ Thyroid Problems
☐ Breast Lump	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis
☐ Bronchitis	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bulimia	☐ Heart Disease	☐ Mumps	☐ Thyphoid Fever
☐ Cancer	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Cataracts	☐ Hernia	☐ Pneumonia	<ul><li>☐ Vaginal Infections</li><li>☐ Venereal Disease</li></ul>

## CONFIDENTIAL HEALTH HISTORY

Have you ever had a blood transfusion?   Yes   No   If yes, please give approximate dates:   PREGNANCY HISTORY   Took (r/ ) which show much you use per day/week.   PREGNANCY HISTORY   Stress   Catteine   Cat	11000		ATIONIC									
Have you ever had a blood transfusion?		IIALIZ				Reason fo	or Ho	spitalization and Outcome				
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COCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:  Stress								S   INO				
Check () if your work exposes you to the following:  Stress Gaffeine Hazardous Substances Complications if any  Drugs Other  SERIOUS ILLNESS/INJURIES  DATE  OUTCOME  FAMILY HISTORY Fill in health information about your family.  Cause of Death Disease Relation Mother Brothers  Cancer Cancer Cancer Cancer Cancer Cancer Cancer Cancer Cancer Chemical Dependency Chemic								HADITE Chook (14) which		DECN	NCV LISTORY	
Stress   Caffeine   Hazardous Substances   Tobacco   Heavy Lifting   Drugs   Date      Heavy Lifting   Drugs   Date   Date	Chec	k (🖊) if y	our work ex	_		substa						
Hazardous Substances   Tobacco   Heavy Lifting   Drugs     Other   Alcohol      SERIOUS ILLNESS/INJURIES   DATE   OUTCOME      FAMILY HISTORY   Fill in health information about your family.   Relation   Age   State of   Age of   Health   Death   Cause of Death   Disease   Relationship to you     Father   Arthritis, Gout     Mother   Asthma, Hay Fever     Brothers   Cancer   Cancer     Cancer   Chemical Dependency     Diabetes   Heart Disease, Strokes     Heart Disease   Heart Disease     Heart Disease   Tuberculosis     Certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or ommisions that I may have made in the completion of this form.			g:					· · · · · · · · · · · · · · · · · · ·	Birth	Birth	Complications if any	
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Relation   Age   Health   Death   Cause of Death   Disease   Relationship to you	FAMIL	Y HIS	TORY F	ill in heal	th inf	ormation a	bout	your family.				
Father	Relation	Age				Cause of D	eath		ood rela	itives ha		
Mother		+	Health	Death							Relationship to you	
Brothers		+							Vor			
Chemical Dependency Diabetes Heart Disease, Strokes High Blood Pressure Kidney Disease Tuberculosis Other  I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or ommisions that I may have made in the completion of this form.  Signature Date		+							VGI			
Diabetes   Heart Disease, Strokes   High Blood Pressure   Kidney Disease   Tuberculosis   Other	Diomers	•							ndonev			
Heart Disease, Strokes   High Blood Pressure   Kidney Disease   Tuberculosis   Other								-	idelicy			
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Kidney Disease   Tuberculosis   Other	<b></b>											
Tuberculosis  Other  I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or ommisions that I may have made in the completion of this form.  Signature  Date	Sisters								sure			
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