HEALTH HISTORY (Confidential)

Name		Today	Today's Date			
Age Birthdate_	Date	of last physical examination				
What is your reason for visit?.						
SYMPTOMS Check (✓) symp	toms you currently have or have	had in the past year.				
GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROA	T MEN only			
Chills	Appetite poor	☐ Bleeding gums	☐ Breast lump			
☐ Depression	Bloating	☐ Blurred vision	☐ Erection difficulties			
Dizziness	☐ Bowel changes	Crossed eyes	☐ Lump in testicles			
☐ Fainting	☐ Constipation	☐ Difficulty swallowing	Penis discharge			
Fever	☐ Diarrhea	☐ Double vision	☐ Sore on penis			
Forgetfulness	☐ Excessive hunger	☐ Earache	Other			
☐ Headache	Excessive thirst	☐ Ear discharge	WOMEN only			
☐ Loss of sleep	Gas	☐ Hay fever	Abnormal Pap Smear			
Loss of weight	Hemorrhoids	☐ Hoarseness	Bleeding between periods			
☐ Nervousness	☐ Indigestion	☐ Loss of hearing	☐ Breast lump			
Numbness	☐ Nausea	Nosebleeds	Extreme menstrual pain			
Sweats	☐ Rectal bleeding	Persistent cough	☐ Hot flashes			
MUSCLE/JOINT/BONE	Stomach pain	☐ Ringing in ears	☐ Nipple discharge			
Pain, weakness, numbness in:	☐ Vomiting	☐ Sinus problems	☐ Painful intercourse			
☐ Arms ☐ Hips	☐ Vomiting blood	☐ Vision – Flashes	□ Vaginal discharge			
☐ Back ☐ Legs	CARDIOVASCULAR	☐ Vision – Halos	Other			
☐ Feet ☐ Neck	Chest pain	SKIN	Date of last			
☐ Hands ☐ Shoulders	☐ High blood pressure	☐ Bruise easily	menstrual period			
GENITO-URINARY	☐ Irregular heart beat	☐ Hives	Date of last			
☐ Blood in urine	Low blood pressure	☐ Itching	Pap Smear			
☐ Frequent urination	☐ Poor circulation	☐ Change in moles	Have you had			
Lack of bladder control	☐ Rapid heart beat	Rash	a mammogram?			
☐ Painful urination	Swelling of ankles	Scars	Are you pregnant?			
	☐ Varicose veins	☐ Sore that won't heal	Number of children			
CONDITIONS Check (✓) cond	ditions you have or have had in th	ne past.				
AIDS	☐ Chemical Dependency	☐ High Cholesterol	☐ Prostate Problem			
Alcoholism	☐ Chicken Pox	☐ HIV Positive	☐ Psychiatric Care			
☐ Anemia	Diabetes	☐ Kidney Disease	☐ Rheumatic Fever			
☐ Anorexia	☐ Emphysema	Liver Disease	☐ Scarlet Fever			
☐ Appendicitis	☐ Epilepsy	☐ Measles	Stroke			
☐ Arthritis	☐ Glaucoma	☐ Migraine Headaches	☐ 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 medication	CATIONS List medications you are currently taking ALLERGIES To medications					

Phone__

Pharmacy Name_

(All information is strictly confidential)

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