Confidential Health History- NEW PATIENT (Side One)

Name_____ Today's Date_____
Age _____ Birthdate_____ Date of last examination _____

Conditions: circle conditions you have or have had in the past year

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical dependency
- High Blood Pressure
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High Cholesterol
- HIV Positive
- Kidney Diease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio
- Prostate Problems
- Psychiatric care
  Rectal bleeding
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease
- OTHER _____

Reason for today's visit?

_____
_____

Previous Hospitalizations/ Past Surgeries/Serious Injuries *with dates*

_____
_____
_____
_____

Current Medications. Please include Herbal Supplements and Vitamins *with doses*

_____
_____
_____

List any Medication Allergies:

_____
_____

Social History

Occupation**:** _____ Retired yes ___ no___
Marital Status: Single__ Married__ Divorced__ Widowed __ Separated__
Use of Alcohol Never__ Rarely__ Moderate__ Daily__ Type_____
Use of Tobacco Never__ Previously, quit date_____ Current packs/day_____
Use of Street Drugs Never____ Type/Frequency_____
Excessive exposure at home or work to: Fumes__ Dust__ Solvents__
Noise__ Airborne Solvents__

Family History

	Age	Diseases/Cause of Death
Father	___	_____
Mother	___	_____
Siblings	___	_____
	___	_____
	___	_____
Other Family	___	_____

OVER

Confidential Health History- NEW PATIENT (Side Two)

Name_____ Today's Date_____

Systems Review

Constitutional Symptoms
Good general health lately..... No/Yes
Recent weight change..... No/Yes
Fever..... No/Yes
Fatigue..... No/Yes
Headaches..... No/Yes

Eyes
Eye disease or injury..... No/Yes
Wear glasses/contact lenses..... No/Yes
Blurred or double vision..... No/Yes
Glaucoma..... No/Yes

Ears/Nose /Mouth/Throat
Hearing loss or ringing..... No/Yes
Earache or drainage..... No/Yes
Chronic sinus problems..... No/Yes
Nose bleeds..... No/Yes
Mouth sores..... No/Yes
Bleeding gums..... No/Yes
Bad breath or bad taste in mouth..... No/Yes
Sore throat or voice change..... No/Yes
Swollen glands in neck..... No/Yes

Cardiovascular
Heart trouble..... No/Yes
Chest pain or angina..... No/Yes
Palpitations..... No/Yes
Shortness of breath when lying down..... No/Yes
Swelling of feet, ankles or hands..... No/Yes

Respiratory
Chronic or frequent cough..... No/Yes
Spitting up blood ..... No/Yes
Shortness of breath..... No/Yes
Asthma or wheezing..... No/Yes

Gastrointestinal
Loss of appetite..... No/Yes
Change in bowel movement..... No/Yes
Nausea or vomitting..... No/Yes
Frequent diarrhea..... No/Yes
Constipation/painful BM..... No/Yes
Rectal bleeding or blood in stool..... No/Yes
Abdominal pain or heartburn..... No/Yes
Stomach/duodenal ulcer..... No/Yes

Genitourinary
Sexual difficulty..... No/Yes
Kidney stones..... No/Yes
Male-testicle pain..... No/Yes
Incontinence or dribbling..... No/Yes
Female: pain with periods..... No/Yes
Female: irregular periods..... No/Yes
Female: vaginal discharge..... No/Yes
Female: # ___pregnancies # ___ children.. No/Yes
Female: Date of last Pap smear..... No/Yes

Musculoskeletal
Joint Pain..... No/Yes
Joint stiffness or swelling..... No/Yes
Muscle weakness..... No/Yes
Muscle pain or cramps..... No/Yes
Back pain..... No/Yes
Cold extremities..... No/Yes
Difficulty in walking..... No/Yes

Skin/Breasts
Rash or itching..... No/Yes
Change in skin color..... No/Yes
Change in hair or nails..... No/Yes
Varicose Veins..... No/Yes
Breast pain..... No/Yes
Breast lump..... No/Yes
Breast discharge..... No/Yes

Neurological
Frequent or recurring headaches..... No/Yes
Light headed or dizzy..... No/Yes
Convulsions or seizures..... No/Yes
Numbness or tingling sensations..... No/Yes
Tremors..... No/Yes
Paralysis..... No/Yes
Stroke..... No/Yes
Head injury..... No/Yes

Psychiatric
Memory loss or confusion..... No/Yes
Nervousness/anxiety..... No/Yes
Depression..... No/Yes
Insomnia..... No/Yes

Endocrine
Glandular or hormone problem..... No/Yes
Thyroid disease..... No/Yes
Diabetes..... No/Yes
Excessive thirst or urination..... No/Yes
Heat or cold intolerance..... No/Yes
Skin becoming drier..... No/Yes
Change in hat or glove size..... No/Yes

Hematologic/lymphatic
Slow to heal after cuts..... No/Yes
Bleeding or bruising tendency..... No/Yes
History of reaction to medications: ..... No/Yes
Antibiotics _____
Morphine, Demerol or narcotics_____
Iodine, methiolate or antiseptics_____
Novocaine or anesthetics _____
Tetanus or other serums _____
Aspirin or pain remedies _____
Other drugs/medication allergies_____
Known food allergies _____

Preferred Pharmacy _____

Patient Signature_____ Reviewed by _____