## **Health History** ( confidential ) \_\_\_\_\_ Today's Date:\_\_\_\_ Patient Name: Date of Birth: \_\_\_ Date of Last Physical Examination:\_\_\_\_ What is Your Reason for Visit? Symptoms (check symptoms you currently have or have had in the past year) General Skin Head Usual weight Rashes Headache Head injuries Recent weight change Lumps Any clothes that feet tighter Sores Dizziness Lightheadedness or looser than before Itching Weakness Dryness **Eyes** Fatigue Color change Fever Changes in hair or nails Glasses or contact lenses Loss of sleep Last exam Pain **Nose and Sinuses Ears** Redness Frequent colds Hearing problems Nasal stuffiness Excessive tearing Use of hearing aids Discharge Double vision Blurred vision Ringing Itching Vertigo Hay fever Spots or specks Pain Nose bleeds Flashing lights Infections Sinus trouble Glaucoma Discharge Cataracts **Mouth and Throat Neck Breasts** Gum pain or toothache Lumps Bleeding gums Lumps Swollen glands Dentures and their fit Pain or discomfort Goiter Last dental exam Nipple discharge Pain Self exam practices Sore tongue Stiffiness

Dry mouth

Hoarseness

Frequent sore throats

	Symptoms continued from P.1	
Respiratory	Cardiac	Gastrointestinal
Cough	Heart trouble	Trouble swallowing
Sputum (color, quantity)	High blood pressure	Heartburn
Coughing up blood	Rheumatic fever	Appetite problems
Difficulty breathing	Murmurs	Nausea
Wheezing	Chest pain/discomfort	Vomiting
Asthma	Palpitations	Regurgitation
Bronchitis	Dificulty breathing when	Vomiting of blood
Emphysema	lying down	Indigestion
Pneumonia	Do you wake up suddenly	Frequency of bowel
Tuberculosis	to sit up and take a breath?	movement
Pleurisy	Edema	Color and size of stool
Chest x-ray (date)	EKG or other tests	Change in bowel habits
_		Rectal bleeding or black
Urinary	Genital (male)	tarry stools
Frequent urination	Hernias	Hemorrhoids
Nocturnal urination	Discharge from or sores on	Constipation/diarrhea
Burning or pain on urination	the penis	Abdominal pain
Blood in urine	Testicular pain or masses	Food intolerance
Reduced caliber or force of the urinary stream	History of STDs (sexually transmitted diseases)	Excessive belching or passing of gas
Hesitancy	Exposure to HIV infection	Jaundice
Dribbling		Liver or gallbladder trouble
Incontinence	Genital (female)	Hepatitis
Urinary infections	Painfull periods	
Kidney or bladder stones	PMS	Musculoskeletal
	Discharge	Muscle or joint pains
Peripheral Vascular	Itching	Stiffness
Aching, cramping, numbness	Sores	Arthritis
and severe fatigue of feet on	Lumps	Gout
walking that disappears with	Pain during intercource	Backache
rest	Number of pregnancies/	
Leg cramps	deliveries/abortions	_
Varicose veins	Menopausal symptoms	
Clots in veins	Post menopausal bleeding	
	History of STDs	
	Exposure to HIV infection	
	Age at menarche	

Symptoms continued from P.2			
Neurological	Hemotologic	Endocrine	
Fainting; blackouts	Anemia	Thyroid trouble	
Vertigo	Easy bruising or bleeding	Heat/cold intolerance	
Seizures	Past transfusions and any	Excessive thirst	
Weakness	reactions to them	or hunger, excessive	
Paralysis		urination	
Numbness	Mental / Emotional		
Tingling; "pins and needles"	Nervousness		
Tremors or other involuntay	Tension		
movements	Depression		
	Memory problems		