

PERSONAL HEALTH HISTORY

Patient: _____ Date of Birth _____
 Last Name First Name Middle Name

What is the main reason for your visit to our clinic today?

Allergies: Do you have any allergies to the following? **(Please select all that apply)**

- | | | | | | |
|--------------------------------------|-------------------------------------|---------------------------------------|---------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Morphine | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> NSAIDS | <input type="checkbox"/> Latex | <input type="checkbox"/> Lidocaine | <input type="checkbox"/> Contrast Dye | <input type="checkbox"/> Sulfites | <input type="checkbox"/> Pollen |
| <input type="checkbox"/> Cats | <input type="checkbox"/> Dogs | <input type="checkbox"/> Mold | <input type="checkbox"/> Dust | <input type="checkbox"/> Bees | <input type="checkbox"/> Soy |
| <input type="checkbox"/> Wheat | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Fish | <input type="checkbox"/> Peanuts | <input type="checkbox"/> Eggs | <input type="checkbox"/> Milk |
| <input type="checkbox"/> Other _____ | | | | | |

Medications: List all medications, over-the-counter medications, vitamins, or other supplements you are taking:

Name of Medication/Supplement	Strength	Frequency Taken

Medical Conditions: Do you currently have or have a history of the following? **(Please select all that apply)**

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Adrenal Disorder | <input type="checkbox"/> Kidney Disease | | |

Surgeries / Hospitalizations: Have you had any of the following surgeries? **(Please select all that apply)**

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Brain Surgery | <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> C-Section |
| <input type="checkbox"/> CABG | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Colon Surgery | <input type="checkbox"/> Cosmetic |
| <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Fracture Surgery | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Prostate Surgery | <input type="checkbox"/> Small Intestine Surgery | <input type="checkbox"/> Spine Surgery |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Tubal Ligation | <input type="checkbox"/> Valve Replacement | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Other: _____ | | | |

Family History: Do you have a family history of any of the following? (Please "X" the boxes that apply to you)

Medical Condition	Mom	Dad	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sister	Mom's Brother	Dad's Sister	Dad's Brother
Alcohol/ Drug Addiction												
Arthritis												
Asthma												
Cancer												
Heart Disease												
Depression												
Diabetes												
High Cholesterol												
High Blood Pressure												
Kidney Disease												
Mental Illness												
Stroke												
Vision Problems												

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Social History: Please answer the following questions regarding your social history:

Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If "YES", how many of the following per week: _____glasses of wine _____shots of liquor _____cans of beer

Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Currently
Partners?	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Both

What is your current birth control method? (Please check all that apply):

- | | | | | | |
|-------------------------------------|---------------------------------------|-----------------------------------|---------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Abstinence | <input type="checkbox"/> Cervical Cap | <input type="checkbox"/> Condom | <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Hormone Patch | <input type="checkbox"/> Implant |
| <input type="checkbox"/> Injection | <input type="checkbox"/> Inserts | <input type="checkbox"/> IUD | <input type="checkbox"/> IUS | <input type="checkbox"/> Pill | <input type="checkbox"/> Rhythm |
| <input type="checkbox"/> Spermicide | <input type="checkbox"/> Sponge | <input type="checkbox"/> Surgical | <input type="checkbox"/> Vaginal Ring | <input type="checkbox"/> Withdrawal | <input type="checkbox"/> None |

Do you currently use any of the following recreational or street drugs? (Please select all that apply):

- | | | | | | |
|------------------------------------|----------------------------------|----------------------------------|--------------------------------------|---------------------------------|------------------------------|
| <input type="checkbox"/> Crack | <input type="checkbox"/> Cocaine | <input type="checkbox"/> Ecstasy | <input type="checkbox"/> IV | <input type="checkbox"/> Heroin | <input type="checkbox"/> LSD |
| <input type="checkbox"/> Marijuana | <input type="checkbox"/> Meth | <input type="checkbox"/> E-Cigs | <input type="checkbox"/> Other _____ | | |

Do you use any of the following tobacco products? (Please select all that apply):

- | | | | | |
|--------------------------------------|---------------------------------|-------------------------------|--------------------------------|---|
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Cigars | <input type="checkbox"/> Pipe | <input type="checkbox"/> Snuff | <input type="checkbox"/> Chew |
| <input type="checkbox"/> Other _____ | | | | Packs per day: _____ |
| Start Date: _____ | | | | Years of smoking: _____ |
| Quit Date: _____ | | | | Ready to Quit? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Review of Systems: Please circle below: Y= Yes, present condition. N=No, never had the condition.

Constitutional

Fever	Y N	Chills	Y N	Weight Loss	Y N
Malaise/Fatigue	Y N	Sweating	Y N	Weakness	Y N

Skin

Rash	Y N	Itching	Y N	Color changes	Y N
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Head, Ears, Eyes, Nose, Throat

Headaches	Y N	Hearing Loss	Y N	Ringing in Ears	Y N
Ear Pain	Y N	Ear Discharge	Y N	Nosebleeds	Y N
Congestion	Y N	Stridor	Y N	Sore Throat	Y N
Migraine headaches	Y N	Jaw/TMJ problems	Y N		

Eyes

Blurred Vision	Y N	Double Vision	Y N	Light Sensitivity	Y N
Eye Pain	Y N	Eye Discharge	Y N	Eye Redness	Y N

Cardiovascular

Chest Pain	Y N	Palpitations	Y N	Shortness of breath lying down	Y N
Claudication	Y N	Leg Swelling	Y N	PND	Y N
Abdominal Pain	Y N	Blood clots	Y N	Heart disease	Y N
Low/high blood pressure	Y N				

Respiratory

Cough	Y N	Coughing up Blood	Y N	Sputum Production	Y N
Shortness of breath	Y N	Wheezing	Y N		
Asthma	Y N				

Gastrointestinal

Heartburn	Y N	Nausea	Y N	Vomiting	Y N
Abdominal Pain	Y N	Diarrhea	Y N	Constipation	Y N
Blood in Stool	Y N	Black/Tarry Stools	Y N		
How many bowel movements per day?	_____				

Genitourinary

Painful Urination	Y N	Urgency	Y N	Frequency	Y N
Blood in urine	Y N	Flank Pain	Y N	Incontinence	Y N
Frequent infections	Y N				

Male Reproductive

Hernias	Y N	Testicular masses	Y N	Sexual difficulty	Y N
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Female Reproductive

Age of first menses _____ Age of last menses (if menopausal) _____ Length of cycle _____
 Duration of menses _____ Date of last annual exam _____ Number of pregnancies _____
 Number of live births _____ Number of miscarriages _____ Number of abortions _____

Musculoskeletal

Muscle Pain	Y N	Neck Pain	Y N	Back Pain	Y N
Joint pain	Y N	Falls	Y N	Muscle spasms	Y N

Endocrine/Heme/Allergies

Excessive thirst	Y N	Env. Allergies	Y N	Easy Bruising/Bleeding	Y N
Cold intolerance	Y N	Excessive hunger	Y N	Heat intolerance	Y N
Diabetes _____		Thyroid problems _____			

Neurological

Dizziness	Y N	Tingling	Y N	Tremor	Y N
Sensory Change	Y N	Speech Change	Y N	Focal Weakness	Y N
Seizures	Y N	Fainting	Y N	Numbness	Y N
Paralysis	Y N	Loss of memory	Y N		

Emotional (Psychiatric)

Depression	Y N	Suicidal Ideas	Y N	Substance Abuse	Y N
Hallucinations	Y N	Nervous/Anxious	Y N	Insomnia	Y N
Memory Loss	Y N	Mood swings	Y N	Tension/stressed	Y N