

Health History

Patient Name: _____

Date of Birth: _____

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Review of Medical Symptoms

Please indicate if you have had problems with (**Past**), current within the past 30 days (**Current**), or never (**Never**) any of the following:

P	C	N		P	C	N		P	C	N		P	C	N	
			Abdominal Pain				Difficulty Urinating				Hoarseness				Poor Circulation
			Bloating/Gas				Dizziness				Indigestion				Rash
			Blood in Stool				Earache				Itching				Ringing in Ears
			Blood in Urine				Excessive Thirst				Lack of Bladder Control				Shortness of Breath
			Bruise Easily				Fainting				Lightheadedness				Sinus Problems
			Change in Bowel Habits				Fever				Nausea				Sore That Won't Heal
			Change in Moles				Forgetfulness				Nervousness				Swollen Ankles
			Change in Vision				Frequent Urination				Night sweats				Unexplained Wt Loss/Gain
			Chest Pain				Hair Loss				Nosebleeds				Vomiting
			Chills				Hearing Loss				Painful Urination				Other:
			Constipation				Headache				Palpitations/Irregular Heartbeat				1.
			Depression				Hemorrhoids				Persistent Cough				2.
			Diarrhea				Hives				Poor Appetite				3.

Social History Please indicate if you have in the (**Past**), current (**Current**), or never (**Never**) any of the following:

	P	C	N	
Do you smoke?				If past or current, how many packs per day? How many years?
Do you drink alcoholic beverages?				If past or current, how much per week?
Caffeine usage?				If past or current, how many cups per day?
Have you ever worked with chemicals, paints, asbestos or other hazardous materials?				If yes, please explain:
Do you follow any specific diet?	Yes	No		If yes, please explain:
Do you exercise on a regular basis?	Yes	No		If yes, please explain:

Prevention

	Yes	No	
Do you wear seat belts?			If no, why not?
Do you wear a bike helmet?			
If there is a gun in your home, do you keep unloaded and out of children's reach?			
Have you ever engaged in any activity which has put you at risk of getting a sexually transmitted disease?			If yes, explain:
Do you wish to be tested for a sexually transmitted disease?			
Do you feel safe at home?			
Do you have smoke/carbon monoxide detectors in your home?			

Men's Health

Please indicate if you have had problems with (**Past**), current within the past 30 days (**Current**), or never (**Never**) any of the following:

P	C	N		P	C	N		P	C	N					
			Breast Lump				Lump in Testicles				Sexually Transmitted Infection				Other:
			Erection Difficulties				Prostate Problem				Sore on Penis/Penile Discharge				

Sexual preference: _____

Women's Health

Please indicate if you have had problems with (**Past**), current within the past 30 days (**Current**), or never (**Never**) any of the following:

P	C	N		P	C	N		P	C	N	Date of Last:				
			Abnormal Pap Smear				Hot Flashes				Sexually Transmitted Infection				Mammogram:
			Abnormal Bleeding				Miscarriage				Vaginal Infections				Menstrual Period:
			Breast Lump				Nipple Discharge				Number of Children:				Pap Smear:
			Extreme Menstrual Cramps				Painful Intercourse				Are you Pregnant:	YES	NO		

Sexual preference: _____

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Vaccinations

Please provide a record of all vaccinations if possible.

	Date		Date		Date		Date
DTAP		HPV		PPD		TDAP	
FLU		MENINGOCOCCAL		PREVNAR 13		VARICELLA	
HEP A		MMR		ROTOTEQ			
HEPB		POLIO		SHINGLES			
HIB		PNEUMOCOCCAL 23		TD			

I CERTIFY 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 OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

Patient Signature

Date

Review By

Date