

# CONFIDENTIAL HEALTH HISTORY

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Birthdate \_\_\_\_\_ Reason for Visit \_\_\_\_\_

## Check symptoms you currently have or have had in the past year.

### General

- Chills
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Forgetfulness
- Headache
- Light Sensitivity
- Loss of Sleep
- Loss of Weight
- Nervous/Tension
- Numbness
- Shortness of Breath
- Sweats

### Muscle/Joint/Bone

- Pain, weakness, numbness or  
Decreased range of motion in:
- Arms
  - Back
  - Feet
  - Shoulders
  - Jaw/TMJ
  - Hips
  - Legs
  - Neck
  - Hands

### Gastrointestinal

- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Excessive Thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Poor Appetite
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood

### Cardiovascular

- Chest Pain
- High Blood Pressure
- High Cholesterol/Lipids
- Irregular or Rapid Heart Beat
- Poor Circulation
- Swelling of Ankles
- Varicose Veins

### Eye, Ear, Nose, Throat

- Bleeding Gums
- Blurred Vision
- Difficulty Swallowing
- Double Vision
- Earache/Ear Discharge
- Hayfever
- Hoarseness
- Loss of Hearing
- Nosebleeds
- Persistent Cough
- Ringing in Ears
- Sinus Problems
- Vision Changes

### Urinary

- Blood in Urine
- Frequent Urination
- Lack of Bladder Control
- Painful Urination

### Skin

- Bruise Easily
- Hives
- Itching/Rash
- Change in Mole/s
- Sore that won't heal

### Men Only

- Erection Difficulties
- Lump in Testicles
- Penis Discharge
- Sore on Penis
- Other \_\_\_\_\_

### Women Only

- Abnormal Pap Smear
- Bleeding between periods
- Breast Lump
- Menstrual Cramps
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge
- Other \_\_\_\_\_

Date of last:  
Menstrual Period \_\_\_\_\_  
Pap Smear \_\_\_\_\_  
Mammogram \_\_\_\_\_  
Are you Pregnant? \_\_\_\_\_  
Number of:  
Pregnancies \_\_\_\_\_  
Children \_\_\_\_\_

## Check conditions you currently have or have had in the past year.

- AIDS/HIV
- Alcoholism
- Allergies/Hayfever
- Anemia
- Appendicitis
- Arthritis
- Asthma
- Auto-immune Disease
- Bleeding Disorder
- Bronchitis
- Cancer
- Cataracts
- Chemical Dependency
- Diabetes
- Eating Disorder
- Eczema
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High Cholesterol
- Irritable Bowel Syndrome
- Kidney Disease
- Liver Disease
- Measles
- Mental Illness
- Migraine
- Mononucleosis
- Multiple Sclerosis
- Neurological Disorder
- Osteoporosis
- Pneumonia
- Prostate Problem
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Thrombosis/Embolism
- Thyroid Disease
- Tonsillitis
- Tuberculosis
- Ulcer
- Sexually Transmitted Disease

### MEDICATIONS

### DRUG ALLERGIES

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

### CURRENT HEALTH CONCERNS

Present injury or health concern: \_\_\_\_\_  
Date of injury or onset of problem: \_\_\_\_\_ Pains are:  sharp  dull  constant  intermittent  
What activities aggravate your condition? \_\_\_\_\_  
What activities alleviate your condition? \_\_\_\_\_  
This condition interferes with:  Work  Sleep  Exercise  Routine  Other \_\_\_\_\_  
Are you seeing another health care provider for this condition? \_\_\_\_\_

### PAST MEDICAL HISTORY

Have you ever been hospitalized or had surgery? \_\_\_\_\_  
For what reasons? \_\_\_\_\_  
Number of Pregnancies Year/s of birth \_\_\_\_\_  
Complications during pregnancy or delivery? \_\_\_\_\_  
Have you ever had a blood transfusion? \_\_\_\_\_ Approximate date: \_\_\_\_\_  
Serious illnesses or injuries? \_\_\_\_\_

### HEALTH HABITS

Check which substances you use:  Caffeine  Tobacco  Alcohol  Recreational Drugs  
Check any work exposures:  Stress  Heavy Lifting  Hazardous Substances  Other \_\_\_\_\_  
Occupation \_\_\_\_\_  
Diet Restrictions/Regimens? Please describe \_\_\_\_\_  
Food allergies or sensitivities? Please list \_\_\_\_\_  
Please list any supplements (vitamins, minerals, herbs, amino acids, etc.) you are currently taking. \_\_\_\_\_

### FAMILY HISTORY

Relation	Age	State of Health	Cause of Death/Age	Check if your blood relatives had any of the following Disease Relationship to you	
Father				Arthritis/Gout	
Mother				Asthma, Hayfever	
Siblings				Cancer	
				Diabetes	
				Heart Disease, Stroke	
				High Blood Pressure	
				Kidney Disease	
				Mental Illness	
				Substance Abuse	
				Tuberculosis	
			Other		

I certify that the above information is correct to the best of my knowledge. I will not hold my health care provider responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date