Health History:

Name: ________________________________ Date of Birth: ________________________

Family History—**Please circle all that apply** **M / F**

Epileps	Thyroid disease	Osteoporosis	Lipid disorders	Migraine
Hay Fever	Arthritis	Alcoholism	Mental Illness	Asthma
Hepatitis	Glaucoma	Anemia	Stroke	Heart Disease
Cancer	Diabetes	Bleeding Disorder	Hypertension	

Hospital Admissions—Years	**Illness or Operation**

Medications—**List all that you are taking** *Allergies*:

Medical History—Mark **(C)** for Current Problems. Check **(X)** and **indicate age** when you had any of the following:

⌈ Hearing Problems	⌈ Ringing in Ears	⌈ Sinus Problems	⌈ Sore Throat	⌈ Dizzy Spells
⌈ Fainting Spells	⌈ Allergies/Hayfever	⌈ Hoarseness	⌈ Vision Problems	⌈ Eye Pain
⌈ Nose Bleeds	⌈ Headaches	⌈ Pneumonia	⌈ Pleurisy	⌈ Bronchitis
⌈ Asthma	⌈ Abdominal Pain	⌈ Chronic Cough	⌈ Hepatitis	⌈ Jaundice
⌈ Wheezing	⌈ Nausea/Vomiting	⌈ Peptic Ulcer	⌈ Hypertension	⌈ Heart Murmur
⌈ Heart burn	⌈ Gall Bladder Disease	⌈ Palpitations	⌈ Chest Pains	⌈ Diarrhea
⌈ Constipation	⌈ Swollen Ankles	⌈ Irregular Pulse	⌈ Diverticulosis	⌈ Bloody Stools
⌈ Short of Breath	⌈ Hemorrhoids	⌈ Hernia	⌈ Leg Pain	⌈ Overactive Bladder
⌈ Cold-Numb Feet	⌈ Urgency to Urinate	⌈ Varicose Veins	⌈ Stress Incontinence	⌈ Decrease in Pee Flow
⌈ Loss of Appetite	⌈ Difficulty swallowing	⌈ Blood in urine	⌈ Kidney Stones	⌈ Weight Loss
⌈ Weight Gain	⌈ UTI	⌈ Prostate Problems	⌈ Anemia	⌈ Bruises Easily
⌈ Cancer	⌈ Fatigues Easily	⌈ Diabetes	⌈ Thyroid Disease	⌈ Seizures
⌈ Stroke	⌈ Tremors	⌈ Numbness	⌈ Arthritis	⌈ Back Pain
⌈ Joint Pain	⌈ Osteoporosis	⌈ Gout	⌈ Rash/hives	⌈ Psoriasis
⌈ Eczema	⌈ Concentration	⌈ Sleep Problems	⌈ Depression	⌈ Nervous
⌈ Moodiness	⌈ Suicidal Thoughts	⌈ Memory Loss	⌈ Decreased Work Enjoyment	⌈ Decreased Life Enjoyment
⌈ Mental Loss	⌈ Rheumatic Fever	⌈ Measles	⌈ Chicken Pox	⌈ Polio
⌈ Mumps	⌈ Tuberculosis	⌈ AIDS/HIV	⌈ STD	⌈ Sexual Problems-Enjoyment
⌈ Alcohol Usage	⌈ Caffeine Usage	⌈ Tobacco Usage	⌈ Street Drugs	⌈ Exercise
⌈	⌈	⌈	⌈	⌈

Females Only

Menstrual Flow: ⌈ Regular ⌈ Irregular ⌈ Excessive ⌈ Painful cramping __________ Days of Cycle First Day of Last Cycle _________ Number of Pregnancies:__________ Abortions: _________ Miscarriages: _________ Live Births:_________
Birth Control Method:____ Date of Last Pap:____________________________
Last Mammogram: ____