Patient #___________

HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name ______________________________ Birth date_______________

Chief Complaint: ______________________________

History of present illness:

Location: ______________________________
(Where is the pain/problem?)

Quality______________________________
(Example: normal versus abnormal color, activity, etc.)

Severity ______________________________
(On a scale of 0 to 10, with 0 being no pain and 10 being severe)

Duration______________________________

Timing ______________________________
(Does the pain/problem occur at a specific time?)

Context ______________________________
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms ______________________________

Modifying factors ______________________________
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

Past Medical History:

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Scarlet Fever..................no yes
Rheumatic Fever............no yes
Heart Disease.................no yes
Migraine Headaches.......no yes
Diabetes..........................no yes
Arrhythmia.....................no yes
Claudication...................no yes
Liver Disease.................no yes
Anxiety..........................no yes
Hypertension..................no yes

High Blood Pressure...............no yes
Low Blood Pressure...............no yes
Cancer....................................no yes
Asthma...................................no yes
Aids or HIV+..........................no yes
Mitral Valve Prolapsed...........no yes
Stroke.....................................no yes
Chest pain/Angina..................no yes
Congestive Heart Failure.........no yes
Shortness of Breath ....no yes

MI..no yes
Kidney Disease..........................no yes
Thyroid Disease.........................no yes
Hyperlipidemia..........................no yes
Heart Palpitations.......................no yes
Heart Murmur............................no yes
Congenital Heart Disease..........no yes
Jehovah Witness........................no yes
Blood Plasma or Plasma Transfusion................................no yes

Previous Hospitalization/Surgeries/Serious Illnesses	When?	Hospital, City, State

Medications: (Include nonprescription) ______________________________

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____

Patient social history:

Marital Status: Single: ________ Married: ________ Separated: _________ Divorced: __________ Widowed: _________

Use of Alcohol: Never: ________ Rarely: _________ Moderate: __________ Daily: _____________

Use of Tobacco: Never: _______ Previously, but quit: _________ Current packs/day: ___________

Use of drugs: Never: _______ Type/Frequency: ______________________________

Family medical history:

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms
- Good general health lately...............no yes
- Recent weight change......................no yes
- Fever...no yes
- Fatigue..no yes
- Headaches.......................................no yes

Genitourinary
- Frequent urination.............no yes
- Blood in urine.....................no yes
- Kidney stones....................no yes
- Sexual difficulty................no yes

Psychiatric
- Memory Loss or confusion.........no yes
- Depression.................................no yes
- Insomnia...................................no yes

Eyes
- Eye disease or injury........................no yes
- Wear glasses/contact lenses. ....no yes
- Blurred or double vision..................no yes

Respiratory
- Chronic/frequent coughs....no yes
- Shortness of breath...........no yes
- Wheezing...........................no yes

Musculoskeletal
- Joint pain....................................no yes
- Joint stiffness or swelling..........no yes
- Muscle pain or cramps...............no yes
- Difficulty in walking..................no yes

Cardiovascular
- Heart trouble...................................no yes
- Chest pain or angina pectoris..........no yes
- Palpitations.....................................no yes
- Shortness of breath w/walking Or lying flat....................................no yes
- Swelling of feet, ankles or hands....no yes

Ear/Nose/Mouth/Throat
- Hearing loss or ringing......no yes
- Nose bleeds......................no yes
- Mouth Sores.....................no yes
- Bleeding gums...................no yes
- Swollen glands in neck.....no yes

Neurological
- Frequent or recurring headaches. no yes
- Numbness or tingling sensations. no yes
- Light headed or dizzy..................no yes
- Convulsions or seizures................no yes

Endocrine
- Glandular or hormone problem.....no yes
- Phlebitis..no yes
- Past transfusion ....no yes
- Slow to heal after cuts..................no yes
- Enlarged glands.............................no yes

Integumentary (skin, breast)
- Rash or itching ....no yes
- Change in hair or nails........no yes
- Varicose veins....................no yes
- Breast pain.........................no yes
- Breast lump........................no yes
- Breast discharge.................no yes

Allergic/Immunologic

History of skin reaction or other adverse reaction to:
- Penicillin or other anesthetics.......no yes
- Morphine, Demerol, or other narcotics...........................no yes
- Novocain or other pain remedies. no yes
- Aspirin or other pain remedies......no yes
- Tetanus antitoxin or other serums.no yes
- Iodine, Merthiolate or other Antiseptic.....................................no yes

Gastrointestinal
- Loss of appetite...........................no yes

Known food allergies:

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____

What type of reaction do you have to the above allergy?

Shock ________ **Nausea** _______ **Skin Rash** _______ **Diarrhea** _______ **Unconsciousness** ________ **Anaphylatis** __________

Other: ____

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

____ ______________________

Signature of Patient, Parent or Guardian **Date**

Doctor's Review

____ ______________________

Signature of Doctor **Date**