PATIENT HEALTH HISTORY

This form will become part of your medical record. You may be asked to periodically update this form.

Name:_____ Date:_____ Family MD:_____

Height:_____ Weight:_____ Date of Birth:_____ Pharmacy:_____

Were you referred to our office today? [ ] No [ ] Yes Who is the referring doctor?_____

What kind of symptoms are you having that you are seeing the doctor today? _____

_____

How long have you had these symptoms? _____

Do you wear hearing aids? [ ] No [ ] Yes If yes, where did you obtain your hearing aids? _____

Do you have any of these symptoms?

Constitutional Symptoms: _____None
_____ Fatigue _____ Chills _____ Daytime Somnolence
_____ Fever _____ Weight Loss

Eyes: _____None
_____ Eye Pain _____ Loss or blurring of vision

Ear, Nose & Throat: _____None
_____ Ringing in the ears _____ Dizziness _____ Difficulty swallowing
_____ Hearing Loss _____ Sinusitis _____ Hoarseness

Cardiovascular: _____None
_____ Chest pain at rest _____ Palpitations
_____ Chest pain on exertion _____ Swelling of ankles

Respiratory: _____None
_____ Wheezing _____ Shortness of breath _____ Coughing
_____ Snoring/Apnea _____ Coughing up blood

Gastrointestinal: _____None
_____ Nausea _____ Blood in stool _____ Indigestion and heartburn
_____ Vomiting _____ Abdominal pain

Musculoskeletal: _____None
_____ Joint Pain _____ Muscle pain

Integumentary: _____None
_____ Skin rashes _____ Itching _____ Change in moles

Neurological: _____None
_____ Headaches _____ Blackouts _____ Weakness

Psychiatric: _____None
_____ Anxiety _____ Depression

Endocrine: _____None

_____ Excessive intake of water _____ Heat/Cold intolerance

Hematologic/Lymphatic: _____None

_____ Abnormal bleeding _____ Easy bruising _____ Swelling of lymph glands

Allergic/Immunologic: _____None

_____ Itchy eyes _____ Anaphylaxix _____ Sneezing _____ Hives

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Do you use tobacco? [ ] No [ ] Yes Please circle one: cigarettes cigars chewing tobacco How much? _____

Have you ever smoked? [} No [ ] Yes If yes, when did you quit?_____

If patient is a child, is child exposed to secondhand smoke? [ ] No [ ] Yes

Alcohol use? [ ] No [ ] Yes If yes, how much?_____ Pregnant?_____ Breast Feeding?_____

Caffeine Intake? [ ] No [ ] Yes If yes, how much? _____

Do you have:

_____Anemia
_____Arthritis
_____Bone/Joint deformity
_____Cancer Type _____
_____Diabetes
_____Epilepsy
_____Heart disease
_____High blood pressure
_____Kidney stones
_____Lung Disease
_____Lupus
_____Migraines
_____Tuberculosis

Please list all <u>other</u> medical problems:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please give any <u>significant</u> family medical history:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List all past surgeries:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List all allergies:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List all medications with <u>dosage</u>:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

PATIENT'S NAME: _____