

Good health generally? YES NO  
 Recent weight change? YES NO  
 Loss of appetite? YES NO  
 Fever or night sweats? YES NO  
 Any eye disease? YES NO  
 History of heart trouble ? YES NO who is your cardiologist? \_\_\_\_\_  
 Chest Pain/Palpitations? YES NO  
 Swelling of feet, ankles, hands? YES NO  
 Chronic cough? YES NO  
 Cough/spit with blood? YES NO  
 Shortness of breath? YES NO  
 Wheezing? YES NO  
 Change in bowel movements? YES NO If you are 50 or older..., had a colonoscopy? YES NO  
 Performed by Dr. \_\_\_\_\_ DATE: \_\_\_\_\_  
 Abdominal pain ? YES NO  
 Burning or painful urination? YES NO who is your kidney specialist? \_\_\_\_\_  
 Incontinence? YES NO  
 Joint pain or weakness? YES NO Muscle weakness or cramping YES NO  
 Difficulty walking? YES NO  
 Memory loss or confusion? YES NO  
 Excessive thirst or urination? YES NO Heat or cold intolerance? YES NO  
 Skin or nails drier ? YES NO

#### FEMALES

How many pregnancies have you had? \_\_\_\_\_ Began cycle at age \_\_\_\_\_ 1<sup>st</sup> child born at age \_\_\_\_\_  
 Have you had a hysterectomy? Yes No COMPLETE OR OVARIES INTACT  
 If you have menstrual cycles, when was your last one? \_\_\_\_\_ Last pap smear? \_\_\_\_\_

To the best of my knowledge, the questions on my health history sheet 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 health status or my medications. I also authorize the healthcare staff to perform any necessary services that I may need to care for me.

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Signature of Patient

Date:

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Signature of Guardian

Date:

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Signature of Physician

Date:

# HEALTH HISTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Reason for your appointment with our office: \_\_\_\_\_

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## PAST MEDICAL HISTORY:

Do YOU have	OR	Anyone in your immediate family...
DIABETES	YES NO	Father Mother Sibling Child G'Parent
HEART DISEASE	YES NO	Father Mother Sibling ChildG'Parent
HIGH BLOOD PRESSURE	YES NO	Father Mother Sibling ChildG'Parent
GI CANCER	YES NO	Father Mother Sibling Child G'Parent
BREAST CANCER	YES NO	Father Mother Sibling ChildG'Parent
COLON CANCER	YES NO	Father Mother Sibling ChildG'Parent
KIDNEY DISEASE	YES NO	Father Mother Sibling ChildG'Parent
LUNG CANCER	YES NO	Father Mother Sibling ChildG'parent
PROSTATE CANCER	YES NO	Father Mother Sibling ChildG'Parent
THYROID DISEASE	YES NO	Father Mother Sibling ChildG'Parent
LIVER DISEASE	YES NO	Father Mother Sibling ChildG'Parent
STROKE	YES NO	Father Mother Sibling ChildG'parent
STOMACH ULCERS	YES NO	Father Mother Sibling ChildG'Parent
AIDS OR HIV	YES NO	Father Mother Sibling ChildG'Parent

\*\*\*ARE YOU ON ANY MEDICATION FOR BLOOD THINNING?

If so, please list medication, mg. and how often you take it \_\_\_\_\_

Please list all your previous surgeries

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

Please list ALL your daily medications, mgs., and how you take them

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

**SOCIAL HISTORY:**

Do you smoke?      Yes    No      amount per day \_\_\_\_\_

Do you drink alcohol    Yes    No      daily \_\_\_\_\_ weekly \_\_\_\_\_ occasionally \_\_\_\_\_

What is your occupation \_\_\_\_\_

Retired? \_\_\_\_\_ From what occupation \_\_\_\_\_

Disability, explain \_\_\_\_\_

