

PATIENT Health History

Patient Name: _____ Birthdate: _____ Date: _____

Drug Allergies: _____

Medications: _____

Please check the boxes below associated with any symptom(s) that you are experiencing now or have recently experienced.

Constitutional

- | | | | | | |
|-------------|--------------------------|-------------------|--------------------------|-------------|--------------------------|
| Chills | <input type="checkbox"/> | Decline in Health | <input type="checkbox"/> | Fatigue | <input type="checkbox"/> |
| Fever | <input type="checkbox"/> | Weakness | <input type="checkbox"/> | Weight Gain | <input type="checkbox"/> |
| Weight Loss | <input type="checkbox"/> | | | | |

Head

- | | | | | | |
|-----------|--------------------------|----------|--------------------------|-------------|--------------------------|
| Dizziness | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | Head Injury | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | Pain | <input type="checkbox"/> | Sweats | <input type="checkbox"/> |

Eyes

- | | | | | | |
|--------------------|--------------------------|-------------------|--------------------------|------------|--------------------------|
| Blurry Vision | <input type="checkbox"/> | Cataracts | <input type="checkbox"/> | Discharge | <input type="checkbox"/> |
| Double Vision | <input type="checkbox"/> | Excessive Tearing | <input type="checkbox"/> | Eye Pain | <input type="checkbox"/> |
| Eyeglass Use | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | Infections | <input type="checkbox"/> |
| Pain with Light | <input type="checkbox"/> | Recent Injury | <input type="checkbox"/> | Redness | <input type="checkbox"/> |
| Unusual Sensations | <input type="checkbox"/> | Vision Loss | <input type="checkbox"/> | | |

Nose

- | | | | | | |
|------------------|--------------------------|-------------------|--------------------------|------------|--------------------------|
| Discharge | <input type="checkbox"/> | Frequent Colds | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> |
| Infections | <input type="checkbox"/> | Nasal Obstruction | <input type="checkbox"/> | Nosebleeds | <input type="checkbox"/> |
| Sinus Infections | <input type="checkbox"/> | | | | |

PATIENT Health History

Mouth

Bleeding Gums	<input type="checkbox"/>	Change in Dentition	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>
Postnasal Drip	<input type="checkbox"/>	Tongue Burning	<input type="checkbox"/>	Voice Changes	<input type="checkbox"/>

Ears

Discharge	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Hearing Aid	<input type="checkbox"/>
Hearing Impairment	<input type="checkbox"/>	Infections	<input type="checkbox"/>	Pain	<input type="checkbox"/>
Ringling in Ears	<input type="checkbox"/>				

Throat/Neck

Frequent Sore Throat	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	Tenderness	<input type="checkbox"/>
Tonsils Enlarged	<input type="checkbox"/>				

Respiratory

Asthma	<input type="checkbox"/>	Cough	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	Coughing Blood	<input type="checkbox"/>	Pain	<input type="checkbox"/>
Pleurisy	<input type="checkbox"/>	Positive TB Test	<input type="checkbox"/>	Recent Chest X-Ray	<input type="checkbox"/>
Short of Breath	<input type="checkbox"/>	Sputum	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>

Cardiovascular

Chest Pain	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>
Extremity (s) Cool	<input type="checkbox"/>	Extremity(s) Discolored	<input type="checkbox"/>	Hair Loss on Legs	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	Heart Test (not EKG)	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
History of Heart Attack	<input type="checkbox"/>	Leg Pain-Walking	<input type="checkbox"/>	Recent Electrocardiogram	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	Short of Breath-Exertion	<input type="checkbox"/>	Short of Breath-Lying Flat	<input type="checkbox"/>
Short of Breath-Sleeping	<input type="checkbox"/>	Swelling of Legs	<input type="checkbox"/>	Thrombophlebitis	<input type="checkbox"/>
Ulcers on Legs	<input type="checkbox"/>				

PATIENT Health History

Gastrointestinal

- | | | | | | |
|--------------------|--------------------------|------------------------|--------------------------|---------------------|--------------------------|
| Abdominal Pain | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> |
| Heartburn | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> |
| Rectal Bleeding | <input type="checkbox"/> | Abdominal X-Ray Tests | <input type="checkbox"/> | Antacid Use | <input type="checkbox"/> |
| Black Tarry Stools | <input type="checkbox"/> | Change in BM Frequency | <input type="checkbox"/> | Decreased Appetite | <input type="checkbox"/> |
| Excessive Hunger | <input type="checkbox"/> | Excessive Thirst | <input type="checkbox"/> | Gallbladder Disease | <input type="checkbox"/> |
| Hemorrhoids | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | Infections | <input type="checkbox"/> |
| Laxative Use | <input type="checkbox"/> | Nausea | <input type="checkbox"/> | Rectal Pain | <input type="checkbox"/> |
| Swallowing Problem | <input type="checkbox"/> | Vomiting | <input type="checkbox"/> | Vomiting Blood | <input type="checkbox"/> |

Musculoskeletal

- | | | | | | |
|-------------------|--------------------------|------------------|--------------------------|-----------------|--------------------------|
| Arthritis | <input type="checkbox"/> | Joint Pain | <input type="checkbox"/> | Gout | <input type="checkbox"/> |
| Back Problems | <input type="checkbox"/> | Deformities | <input type="checkbox"/> | Joint Stiffness | <input type="checkbox"/> |
| Muscle Cramps | <input type="checkbox"/> | Muscle Stiffness | <input type="checkbox"/> | Paralysis | <input type="checkbox"/> |
| Restricted Motion | <input type="checkbox"/> | Weakness | <input type="checkbox"/> | | |

Psychiatric

- | | | | | | |
|-----------------------|--------------------------|-------------------|--------------------------|----------------|--------------------------|
| Depression | <input type="checkbox"/> | Behavioral Change | <input type="checkbox"/> | Disorientation | <input type="checkbox"/> |
| Memory Loss | <input type="checkbox"/> | Mood Changes | <input type="checkbox"/> | Nervousness | <input type="checkbox"/> |
| Psychiatric Disorders | <input type="checkbox"/> | | | | |

Breasts

- | | | | | | |
|------------------|--------------------------|------------|--------------------------|------|--------------------------|
| Discharge | <input type="checkbox"/> | Lumps | <input type="checkbox"/> | Pain | <input type="checkbox"/> |
| Self-Examination | <input type="checkbox"/> | Tenderness | <input type="checkbox"/> | | |

Skin

- | | | | | | |
|------------------------|--------------------------|---------------------|--------------------------|---------------------|--------------------------|
| Eczema | <input type="checkbox"/> | Itching | <input type="checkbox"/> | Dryness | <input type="checkbox"/> |
| Easy Bruisability | <input type="checkbox"/> | Hair Dye | <input type="checkbox"/> | Hair Texture Change | <input type="checkbox"/> |
| Hives | <input type="checkbox"/> | Lumps | <input type="checkbox"/> | Mole Increase Size | <input type="checkbox"/> |
| Nail Appearance Change | <input type="checkbox"/> | Nail Texture Change | <input type="checkbox"/> | Rashes | <input type="checkbox"/> |
| Skin Color Change | <input type="checkbox"/> | | | | |

PATIENT Health History

Neurological

- | | | | | | |
|-----------------------|--------------------------|------------------|--------------------------|---------------|--------------------------|
| Loss of Consciousness | <input type="checkbox"/> | Blackouts | <input type="checkbox"/> | Burning | <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | Head Injury | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | Memory Loss | <input type="checkbox"/> | Numbness | <input type="checkbox"/> |
| Paralysis | <input type="checkbox"/> | Speech Disorders | <input type="checkbox"/> | Strokes | <input type="checkbox"/> |
| Tingling | <input type="checkbox"/> | Tremors | <input type="checkbox"/> | Unsteady Gait | <input type="checkbox"/> |

Endocrine

- | | | | | | |
|------------------|--------------------------|---------------------|--------------------------|------------------|--------------------------|
| Weakness | <input type="checkbox"/> | Weight Gain | <input type="checkbox"/> | Weight Loss | <input type="checkbox"/> |
| Cold Intolerance | <input type="checkbox"/> | Excessive Urination | <input type="checkbox"/> | Fatigue | <input type="checkbox"/> |
| Goiter | <input type="checkbox"/> | Heat Intolerance | <input type="checkbox"/> | Increased Thirst | <input type="checkbox"/> |
| Neck Pain | <input type="checkbox"/> | Sweats | <input type="checkbox"/> | Thyroid Trouble | <input type="checkbox"/> |

Hematologic/Lymphatic

- | | | | | | |
|----------------|--------------------------|----------------------|--------------------------|--------------------|--------------------------|
| Anemia | <input type="checkbox"/> | Bleeding Easily | <input type="checkbox"/> | Blood Clots | <input type="checkbox"/> |
| Easy Bruising | <input type="checkbox"/> | Lumps | <input type="checkbox"/> | Radiation Exposure | <input type="checkbox"/> |
| Swollen Glands | <input type="checkbox"/> | Transfusion Reaction | <input type="checkbox"/> | | |

Allergic/Immunologic

- | | | | | | |
|-------------|--------------------------|------------------------|--------------------------|------------------------|--------------------------|
| Coughing | <input type="checkbox"/> | Coughing with Exercise | <input type="checkbox"/> | Hives | <input type="checkbox"/> |
| Itchy Eyes | <input type="checkbox"/> | Itchy Nose | <input type="checkbox"/> | Recurrent Infections | <input type="checkbox"/> |
| Runny Nose | <input type="checkbox"/> | Sneezing | <input type="checkbox"/> | Stuffy Nose | <input type="checkbox"/> |
| Watery Eyes | <input type="checkbox"/> | Wheezing | <input type="checkbox"/> | Wheezing with Exercise | <input type="checkbox"/> |

Urinary

- | | | | | | |
|----------------------|--------------------------|----------------------------|--------------------------|---------------------|--------------------------|
| Awakening to Urinate | <input type="checkbox"/> | Bed Wetting | <input type="checkbox"/> | Blood in Urine | <input type="checkbox"/> |
| Burning | <input type="checkbox"/> | Difficulty Starting Stream | <input type="checkbox"/> | Excessive Urination | <input type="checkbox"/> |
| Flank Pain | <input type="checkbox"/> | Frequency | <input type="checkbox"/> | Incontinence | <input type="checkbox"/> |
| Infections | <input type="checkbox"/> | Pain on Urination | <input type="checkbox"/> | Retention | <input type="checkbox"/> |
| Stones | <input type="checkbox"/> | Urgency | <input type="checkbox"/> | Urine Discoloration | <input type="checkbox"/> |
| Urine Odor | <input type="checkbox"/> | | | | |

PATIENT Health History

Male Genitalia

- | | | | | | |
|-------------------|--------------------------|--------------------|--------------------------|-----------------|--------------------------|
| Discharge | <input type="checkbox"/> | Fertility Problems | <input type="checkbox"/> | Hernias | <input type="checkbox"/> |
| Impotence | <input type="checkbox"/> | Lesions | <input type="checkbox"/> | Pain | <input type="checkbox"/> |
| Prostate Problems | <input type="checkbox"/> | Scrotal Masses | <input type="checkbox"/> | Sexual Problems | <input type="checkbox"/> |
| Venereal Disease | <input type="checkbox"/> | | | | |

Female Genitalia

- | | | | | | |
|-------------------------|--------------------------|----------------------------|--------------------------|----------------------------|--------------------------|
| Birth Control | <input type="checkbox"/> | Bleeding Between Periods | <input type="checkbox"/> | Change in Periods-Duration | <input type="checkbox"/> |
| Change in Periods-Flow | <input type="checkbox"/> | Change in Periods-Interval | <input type="checkbox"/> | DES Exposure | <input type="checkbox"/> |
| Difficult Pregnancy | <input type="checkbox"/> | Discharge | <input type="checkbox"/> | Fertility Problems | <input type="checkbox"/> |
| Hernias | <input type="checkbox"/> | Itching | <input type="checkbox"/> | Lesions | <input type="checkbox"/> |
| Menopause | <input type="checkbox"/> | Menstrual Pain | <input type="checkbox"/> | Pain on Intercourse | <input type="checkbox"/> |
| Postmenopausal Bleeding | <input type="checkbox"/> | Recent Pap Smear | <input type="checkbox"/> | Recent Pregnancy | <input type="checkbox"/> |
| Sexual Problems | <input type="checkbox"/> | Venereal Disease | <input type="checkbox"/> | | |

Other