HEALTH HISTORY

PLEASE FILL OUT THIS FORM CAREFULLY AS THE INFORMATION WILL BE USED AS PART OF YOUR HEALTH RECORD. ALL INFORMATON ON THIS FORM WILL BE KEPT **CONFIDENTIAL**. THANK YOU

NAME: _____

REASON FOR YOUR VISIT/PRESENT MEDICAL PROBLEMS:

_____

_____

_____

CIRCLE ANY OF THE FOLLOWING **YOU'VE** HAD:

ALCOHOLISM	LIVER DISEASE	STROKE
ANEMIA	HEPATITIS	EYE PROBLEMS BLEED
EASY BLEEDING	CANCER/TUMOR	PHLEBITIS
DIABETES	ULCER IN STOMACH OF DUODENUM	THYROID DISEASE
DRUG ABUSE	EPILEPSY	RHEUMATOID FEVER
DEPRESSION	GLAUCOMA	HIGH BLOOD PRESSURE
ECZEMA, HIVES, RASHES	HEART DISEASE	

DO YOU USE ANY OF THE FOLLOWING?

ALCOHOL YES ____ NO____ HOW OFTEN? _____

ASPIRIN YES ____ NO____ HOW OFTEN? _____

IBUPROFEN YES ____ NO____ HOW OFTEN? _____

LAXATIVES YES ____ NO____ HOW OFTEN? _____

CIGARETTES YES ____ NO____ HOW OFTEN? _____

PLEASE LIST ALL OTHER ILLNESSES OR PROBLEMS, FOR WHICH YOU SEE ANOTHER PHYCISICIAN OR MENTAL HEALTH PRACTITIONER:

_____

_____

_____

MEDICINES YOU ARE CURRENTLY TAKING: (LIST MEDICINES, BIRTH CONTROL PILLS, VITAMINS OR ALLERGY MEDICATIONS YOU TAKE WITH OR WITHOUT A PRESCRIPTION INCLUDE MEDICATION, DOSAGE AND FREQUESNCY.)

_____

_____

_____

_____

_____

_____

MEDICINE ALLERGIES (LIST THOSE YOU ARE ALLERGIC TO AND WHAT KIND REACTION YOU HAD.)

_____

_____

_____

SOCIAL HISTORY:

WHAT IS YOUR NATIONAL OR ETHIC ORIGIN? _____

WHERE WERE YOU BORN? _____

HOW DO YOU RATE OVERALL HEALTH? _____

OCCUPATION? _____

LAST SCHOOL GRADE COMPLETED? _____

OTHER HOUSEHOLD MEMBERS? _____

PLEASE LIST PREVIOUS (MOST RECENT) EXAMS AND TESTS:

	YEAR	ABNORMAL		YEAR	ABNORMAL
CHEST X-RAY	_____	_____	MAMMOGRAM	_____	_____
EKG	_____	_____	GENERAL CHECK UP	_____	_____
GI X-RAY	_____	_____	LAST EYE EXAM	_____	_____
PAP SMEAR	_____	_____	COLONOSOSCOPY	_____	_____

IMMUNIZATION: (CHECK THOSE THAT YOU HAVE HAD. **NOTE**: INDICATE YEAR RECEIVED.)

PNEUMONIA _____ RUEBELLA _____ FLU VAC _____

T B SKIN TEST _____ TETANUS _____

HEALTH OF YOUR FAMILY: (LIST ALL HEALTH PROBLEMS. IF DECEASED PLEASE STATE CAUSE AND AGE)

FATHER: _____ SISTERS: _____

MOTHER: _____ CHILDREN: _____

BROTHERS: _____ _____

HAS ANY OF YOUR BLOOD RELATIVES EVER HAD?

TUBERCULOSIS KIDNEY DISEASE CANCER MENTAL ILLNESS
MIGRAINES DIABETES BLEEDING DISORDER

PLEASE ANSWER THE FOLLOWING YES OR NO:

HAVE YOU LOST OR GAINED MOR THAN 10 LBS IN THE LAST 6 MONTHS? _____

DO YOU HAVE FEVER, CHILLS, OR NIGHT SWEATS? _____

HAVE YOU BEEN DEPRESSED, BLUE, DISCOURAGED, OR HAD CRYING SPELLS? _____

DO YOU HAVE ANY SKIN PROBLEMS SUCH AS A MOLE HAS CHANGED APPEARANCE? _____

DO YOU HAVE ANY HAY FEVER OR SEASONAL ALLERGIES? _____

FOR WOMEN ONLY:

START OF LAST MENSTRAL PERIOD: _____

AGE OF MENOPAUSE OR HYSTERECTOMY: _____

METHOD OF CONTRACEPTION: _____

ARE PERIODS REGULAR? _____

DO YOU HAVE PRE-MENSTRAL SYSTOMS? _____

ANY LUMP/PAIN IN BREASTS? _____

DO YOU HAVE ANY VAGINAL ITCHING OR DISCHARGE? _____

HAVE YOU EVER HAD ANY INFECTIONS OF YOUR TUBES OR OVARIES? _____

HAVE YOU EVER HAD ABNORMAL PAP? _____

NUMBER OF CHILDREN: _____ MISCARRIAGES: _____ ABORTIONS: _____