

# Health History

Name \_\_\_\_\_ Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

What is your reason for *today's* visit? \_\_\_\_\_ If applicable, date of injury \_\_\_\_\_

**SYMPTOMS** Check symptoms you currently have or have had in the *past year*.

|   |  |   |   |
|---|--|---|---|
| <p><b>GENERAL</b></p> <input type="checkbox"/> Chills<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Fever<br><input type="checkbox"/> Forgetfulness<br><input type="checkbox"/> Headache<br><input type="checkbox"/> Loss of sleep<br><input type="checkbox"/> Loss of weight<br><input type="checkbox"/> Nervousness<br><input type="checkbox"/> Numbness<br><input type="checkbox"/> Sweats | <p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Poor appetite<br><input type="checkbox"/> Bloating<br><input type="checkbox"/> Bowel changes<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Excessive hunger<br><input type="checkbox"/> Excessive thirst<br><input type="checkbox"/> Gas<br><input type="checkbox"/> Hemorrhoids<br><input type="checkbox"/> Indigestion<br><input type="checkbox"/> Nausea<br><input type="checkbox"/> Rectal bleeding<br><input type="checkbox"/> Stomach pain<br><input type="checkbox"/> Vomiting<br><input type="checkbox"/> Vomiting blood | <p><b>EYE, EAR, NOSE, THROAT</b></p> <input type="checkbox"/> Bleeding gums<br><input type="checkbox"/> Blurred vision<br><input type="checkbox"/> Crossed eyes<br><input type="checkbox"/> Difficulty swallowing<br><input type="checkbox"/> Double vision<br><input type="checkbox"/> Earache<br><input type="checkbox"/> Ear discharge<br><input type="checkbox"/> Hay fever<br><input type="checkbox"/> Hoarseness<br><input type="checkbox"/> Loss of hearing<br><input type="checkbox"/> Nosebleeds<br><input type="checkbox"/> Persistent cough<br><input type="checkbox"/> Ringing in ears<br><input type="checkbox"/> Sinus problems<br><input type="checkbox"/> Vision- flashes<br><input type="checkbox"/> Vision- halos | <p><b>MEN only</b></p> <input type="checkbox"/> Breast lump<br><input type="checkbox"/> Erection difficulties<br><input type="checkbox"/> Lump in testicles<br><input type="checkbox"/> Penis discharge<br><input type="checkbox"/> Sore on penis<br><input type="checkbox"/> Other   |
| <p><b>MUSCLE/JOINT/BONE</b><br/>Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips<br><input type="checkbox"/> Back <input type="checkbox"/> Legs<br><input type="checkbox"/> Feet <input type="checkbox"/> Neck<br><input type="checkbox"/> Hands <input type="checkbox"/> Shoulders   | <p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Chest pain<br><input type="checkbox"/> High blood pressure<br><input type="checkbox"/> Irregular heart beat<br><input type="checkbox"/> Low blood pressure<br><input type="checkbox"/> Poor circulation<br><input type="checkbox"/> Rapid heart beat<br><input type="checkbox"/> Swelling of ankles<br><input type="checkbox"/> Varicose veins   | <p><b>SKIN</b></p> <input type="checkbox"/> Bruise easily<br><input type="checkbox"/> Hives<br><input type="checkbox"/> Itching<br><input type="checkbox"/> Change in moles<br><input type="checkbox"/> Rash<br><input type="checkbox"/> Scars<br><input type="checkbox"/> Sore that won't heal   | <p><b>WOMEN only</b></p> <input type="checkbox"/> Abnormal pap smear<br><input type="checkbox"/> Bleeding between periods<br><input type="checkbox"/> Breast lump<br><input type="checkbox"/> Extreme menstrual pain<br><input type="checkbox"/> Hot flashes<br><input type="checkbox"/> Nipple discharge<br><input type="checkbox"/> Painful intercourse<br><input type="checkbox"/> Vaginal discharge<br><input type="checkbox"/> Other |
| <p><b>GENITO-URINARY</b></p> <input type="checkbox"/> Blood in urine<br><input type="checkbox"/> Frequent urination<br><input type="checkbox"/> Lack of bladder control<br><input type="checkbox"/> Painful urination   |  |   | <p>Date of last menstrual period: _____<br/>                 Date of last pap smear: _____<br/>                 Have you had a mammogram? _____<br/>                 Are you pregnant? _____<br/>                 Number of children: _____</p>   |

**CONDITIONS** Check conditions you *have or have had in the past*

|   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> AIDS<br><input type="checkbox"/> Alcoholism<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Anorexia<br><input type="checkbox"/> Appendicitis<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Bleeding disorders<br><input type="checkbox"/> Breast lump<br><input type="checkbox"/> Bronchitis<br><input type="checkbox"/> Bulimia<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Cataracts | <input type="checkbox"/> Chemical Dependency<br><input type="checkbox"/> Chicken Pox<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> Epilepsy<br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Goiter<br><input type="checkbox"/> Gonorrhea<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Heart disease<br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Hernia<br><input type="checkbox"/> Herpes | <input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> HIV positive<br><input type="checkbox"/> Kidney disease<br><input type="checkbox"/> Liver disease<br><input type="checkbox"/> Measles<br><input type="checkbox"/> Migraine headaches<br><input type="checkbox"/> Miscarriage<br><input type="checkbox"/> Mononucleosis<br><input type="checkbox"/> Multiple sclerosis<br><input type="checkbox"/> Mumps<br><input type="checkbox"/> Pacemaker<br><input type="checkbox"/> Pneumonia<br><input type="checkbox"/> Polio | <input type="checkbox"/> Prostate problem<br><input type="checkbox"/> Psychiatric care<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Scarlet Fever<br><input type="checkbox"/> Stroke<br><input type="checkbox"/> Suicide attempt<br><input type="checkbox"/> Thyroid problems<br><input type="checkbox"/> Tonsillitis<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Typhoid fever<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Vaginal infections<br><input type="checkbox"/> Venereal disease |
|---|---|---|--|

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|--|---|
| <b>MEDICATIONS</b> List medications you are currently taking | <b>ALLERGIES</b> to medications or substances |
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|  |   |
|  |   |

Pharmacy Name \_\_\_\_\_ Phone number \_\_\_\_\_ **OVER** →

