

HEALTH & HISTORY (page 2)

NAME: _____ AGE: _____ MARITAL STATUS: _____ DATE: _____

LIFESTYLE:

Have you ever had a drinking or drug problem? _____

How frequently do you consume alcohol? _____ Last Drink? _____

Do you smoke? _____ Packs per day _____

Did you smoke in the past? _____ Quit when _____

Diet: Favorite foods: _____

Least favorite foods: _____

Favorite Recreations: _____

Do you exercise regularly? _____ What exercise? _____

FAMILY MEDICAL HISTORY:

| | Health | Age if Living | Age at Death | Cause of Death | Circle any diseases that any blood relatives have | Which Relative |
|----------|--------|---------------|--------------|----------------|---|----------------|
| Father | _____ | _____ | _____ | _____ | Cancer | _____ |
| Mother | _____ | _____ | _____ | _____ | Diabetes | _____ |
| Brothers | _____ | _____ | _____ | _____ | High Blood Pressure | _____ |
| Sisters | _____ | _____ | _____ | _____ | Heart Problems | _____ |
| | | | | | Stroke | _____ |

SYMPTOMS: (Circle if you have any of the following recently)

CONSTITUTIONAL

WEIGHT GAIN OR LOSS
NIGHT SWEATS
FEVER/CHILLS

EYES

VISUAL CHANGES
DOUBLE VISION
BLURRY VISION

ENT

EARACHE
RINGING IN EARS
DEAFNESS
DIZZINESS/VERTIGO
SINUS PROBLEMS
BLOODY NOSE
BLEEDING FROM GUMS
TROUBLE SWALLOWING
COUGH

RESPIRATORY

SPUTUM (PHLEGM) _____
COLOR _____ BLOODY? Y N
WHEEZING
DIFFICULTY BREATHING
PAINFUL BREATHING
SHORTNESS OF BREATH
WITH WALKING?
AT NIGHT?
AWAKENING YOU FROM SLEEP?

CARDIOVASCULAR

CHEST PAIN
PALPITATIONS
SLEEP SITTING UP
SWELLING IN ANKLES

NEUROLOGICAL

FAINTING
SEIZURES
NUMBNESS
PARALYSIS
TREMOR
MEMORY PROBLEMS

ALLERGIC/IMMUNOLOGIC

ALLERGIES
IMMUNE PROBLEMS

GASTROINTESTINAL

POOR APPETITE
ABDOMINAL PAIN
NAUSEA/VOMITING
VOMITING BLOOD
DIARRHEA
CONSTIPATION
BLOODY OR TARRY STOOLS
HEARTBURN

GENITOURINARY

PAINFUL URINATION
FREQUENT URINATION
NIGHT TIME URINATION _____ TIMES
URGENT URINATION
TROUBLE STARTING URINATION
INCREASED URINATION
BLOOD IN URINE
IMPOTENCE
DISCHARGE

ARE YOU SEXUALLY ACTIVE?
SEXUAL PROBLEMS?
PAST SEXUAL ABUSE/RAPE?

HEMATOLOGIC/LYMPHATIC

ANEMIA
TRANSFUSIONS IN THE PAST
EASY BRUISING
PERSISTENT BLEEDING
SWOLLEN LYMPH NODES

ENDOCRINE

INCREASED THIRST
HOT OR COLD INTOLERANCE
VOICE CHANGES
CHANGE IN ENERGY LEVEL
INCREASED HUNGER

MUSCULOSKELETAL

SKELETAL DEFORMITIES
JOINT PAIN/SWELLING
MUSCLE WEAKNESS/PAIN

INTEGUMENTARY

SKIN RASH
CHANGING MOLES
BREAST PAIN/LUMP

PSYCHIATRIC

DEPRESSION
ANXIETY
TROUBLE SLEEPING
HALLUCINATIONS
THOUGHTS OF SUICIDE

WOMEN ONLY

NO. OF PREGNANCIES _____
DELIVERIES _____
MISCARRIAGES _____
ABORTIONS _____
ECTOPIC PREGNANCIES _____
AGE MENSES STARTED _____
AGE MENSES STOPPED _____

DO YOU HAVE:

PAINFUL PERIODS? _____
IRREGULAR PERIODS? _____
PAIN WITH SEX? _____
DIFFICULTY GETTING PREGNANT? _____
ARE YOU USING ANY TYPE OF BIRTH CONTROL? _____
WHAT TYPE _____
HAVE YOU USED BIRTH CONTROL IN THE PAST? _____
WHAT TYPE? _____
DATE OF LAST PAP SMEAR: _____
ANY ABNORMALITY _____
COMPLICATIONS OF PREGNANCY? _____
DESCRIBE: _____

