Health History

Name: _____ Date:_____Birthdate:_____

Primary Complaint:_____

Patient Medical History

Diabetes	Yes	No	**Bleeding Tendencies**	Yes	No
Cancer	Yes	No	**Heart Disease**	Yes	No
If yes, what type?_____			**High Blood Pressure**	Yes	No
Lung Disease	Yes	No	**Pulmonary Embolism**	Yes	No

Surgical/Procedure History (*Check all that apply*)

Appendix___ Gallbladder___ Hernia___ Hysterectomy___ Heart/Lung___

Tubal Ligation/Vasectomy___ C-Section___ Biopsy (*Specify*)**___**

If you've had any other surgeries/procedures not listed, please specify:_____

Date of last Colonoscopy:_____ Where was it performed?_____

Allergies (*Check all that apply*)

None Known___ Adhesives___ Local Anesthetics___ Latex___ X-Ray Dye/Contrast___

Other (*Specify*)_____

Medication Allergies Yes No

If yes, please list:_____

_____

_____

Social History (*Check appropriate answer*)

Marital Status: Married___ Single___

Alcohol Use: Never___ Rarely___ Moderate___ Daily___

Caffeine Intake: Never___ Rarely___ Daily___

Tobacco Use: Never___ Quit___ Yes___

E-Cig: No___ Yes___

Chew: No___ Yes___

Street Drug Use: Never___ Yes___ Quit___

If yes, what type: _____

Family Medical History

Father: _____ Alive Deceased

If Deceased: Age___ Reason:_____

Mother: _____ Alive Deceased

If Deceased: Age___ Reason:_____

Sister(s): _____ Alive Deceased

If Deceased: Age___ Reason:_____

Brother(s): _____ Alive Deceased

If Deceased: Age___ Reason:_____

Please Circle only those that you have been diagnosed with or that apply to today's visit:

CONSTITUTIONAL			**CARDIOVASCULAR**		
Unexplained weight loss	Yes	No	Heart Problems	Yes	No
Night sweats	Yes	No	Shortness of breath	Yes	No
Fatigue	Yes	No	Chest pain/Angina	Yes	No
Loss/Gain of appetite	Yes	No	Irregular heart beat	Yes	No
Fever	Yes	No			

RESPIRATORY			**SKIN/BREAST**		
Chronic or frequent cough	Yes	No	Rash/Itching	Yes	No
Asthma	Yes	No	Breast pain	Yes	No
Wheezing	Yes	No	Breast lumps	Yes	No
Shortness of breath	Yes	No	Nipple Discharge	Yes	No

MUSCULOSKELETAL

Joint or muscle pain	Yes	No
Stiffness or swelling	Yes	No

ENDOCRINE

Glandular/Hormonal problem	Yes	No
Thyroid disease	Yes	No
Excessive thirst/Urination	Yes	No

GI/GASTROINTESTINAL

Loss of appetite	Yes	No
Change in bowel movements	Yes	No
Nausea/Vomiting	Yes	No
Frequent Diarrhea	Yes	No
Abdominal pain/Heartburn	Yes	No
Peptic/Gastric ulcers	Yes	No

NEUROLOGICAL

Frequent headaches	Yes	No
Lightheadedness/Dizziness	Yes	No
Convulsions/Seizures/Tremors	Yes	No
Head Injury	Yes	No
Vision Changes/Double Vision	Yes	No

GENITOURINARY

Incontinence	Yes	No
Blood in urine	Yes	No
Increased need to Urinate	Yes	No
Frequent UTI's	Yes	No

HEMATOLOGICAL

Slow to heal after cuts	Yes	No
Bleeding/Bruising	Yes	No
Anemia	Yes	No
Past transfusion	Yes	No

FEMALE ONLY

Menses	Yes	No
Severe Cramps w/ Menses	Yes	No
Hysterectomy	Yes	No

Pregnancies:_____ Deliveries:_____

Miscarriages:_____ Abortions:_____

PSYCHIATRIC

Memory loss	Yes	No
Nervousness	Yes	No
Depression	Yes	No
Insomnia	Yes	No