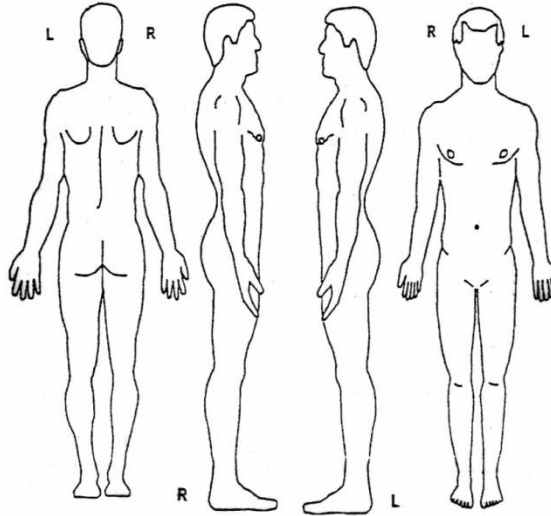


CONFIDENTIAL HEALTH HISTORY

PATIENT NAME: _____ DATE: _____ CHART #: _____

INSTRUCTIONS: Please mark the areas on your body where you feel your PAIN. If the pain radiates, draw an arrow from where the pain starts to where it stops. Please extend the arrows as far as the pain travels.



REVIEW OF SYSTEMS

Please check (✓) symptoms you currently have.

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

PAST MEDICAL HISTORY:

Check (v) conditions or illnesses you have or have had in the past.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Measles | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Gout | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Herpes | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Other | | | |

Past Injuries/Accidents (What, when & result): _____

Past Surgeries/Operations (What, when & result): _____

Hospitalizations (Reason for hospitalization, date, name of hospital): _____

Current Medications: _____

Allergies: _____

FAMILY HISTORY: Please tell us if there is a history of Cancer, Diabetes, Heart Problems, Stroke, Blood Pressure Problems, Headaches, Neck Pain or Surgeries in your FAMILY.

FAMILY HISTORY	LIVING? MEDICAL PROBLEMS IF ANY:	DECEASED? CAUSE OF DEATH:	AGE
Mother			
Father			
Brother			
Brother			
Sister			
Sister			
Child			
Child			

SOCIAL HISTORY:

Marital Status (circle): Single Married Widowed Divorced Separated **Children:** NO/YES If yes, how many? _____

Current Employment/Occupational History: _____

HEALTH HABITS:

Exercise: Type: _____ Freq. ____/week Duration _____ Min/Hrs

Check (v) which you use and how much you use:

- Alcoholic Beverages _____
 Tobacco _____
 Street Drugs _____
 Caffeine _____

Check (v) if your daily activities or work exposes you to:

- Stress _____ Prolonged Sitting/Standing _____
 Heavy Lifting _____ Repetitive Motions _____
 Hazardous Substances _____
 Other _____

Physician Signature: _____ **Date:** _____