

CONFIDENTIAL HEALTH HISTORY

(The information requested is very valuable for your medical assessment.)

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: _____ Male _____ Female

Who is your primary physician? _____ Specialty _____

Who referred you to this office? _____ Specialty _____

What other physicians have you seen in the past?

Name	Specialty	Date of last visit
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is your reason for this visit?

Are you here for a hospital follow-up? _____ Yes _____ No
If "yes"
What hospital _____ When _____
Which physician (s) from this office saw you at the hospital? _____

Are you <u>allergic</u> to any medication?		What <u>medications</u> are you <u>currently</u> taking?	
Name of the drug	Type of reaction?	Name of the drug	When was it started?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any recent vaccines or immunizations?			
What type of vaccine?	When was it given?		
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY

Marital status: _____ Single _____ Married Name of spouse or companion: _____

Do you have any children? _____ Yes _____ No What type of work do you do? _____

Do you smoke? _____ Yes _____ No Drink alcohol? _____ Yes _____ No Other drugs? _____ Yes _____ No

Any special hobbies? _____ Any recent travel? _____ Yes _____ No Where? _____

Did you serve in the Military? _____ Yes _____ No → When? _____ Where? _____

PAST MEDICAL PROBLEMS

Name: _____

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

Abdominal surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endocarditis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gallbladder disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parasitic infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	PID, Pelvic infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anticoagulation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart attack, Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart beat, Irregular	<input type="checkbox"/> Yes <input type="checkbox"/> No	Positive PPD/TB. test	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart failure, CHF	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood clot legs, lung	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood donation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart valve disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sarcoidosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis, Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles, zoster	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Splenectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hysterectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Steroid treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chickenpox	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke (CVA)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic sinusitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicidal attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leg or foot ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Syphilis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Connective tissue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lymes disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
COPD, Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cystic fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Urinary infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diverticular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Non-healing wound	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other illness	_____
Drug addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other surgeries	_____

CURRENT MEDICAL HISTORY

Name: _____

Symptoms

Check (✓) symptoms you currently have or have had in the past 30 days

Weakness	___Yes ___No
Lack of energy	___Yes ___No
Malaise, not feeling well	___Yes ___No
Diffuse body aches	___Yes ___No
Faintness, syncope	___Yes ___No
Inability to sleep	___Yes ___No
Dizziness, vertigo	___Yes ___No
Depression	___Yes ___No
Chills	___Yes ___No
Night sweats	___Yes ___No
Unusual headaches	___Yes ___No
Skin rash, hives	___Yes ___No
Itching	___Yes ___No
Bruise easily	___Yes ___No
Sore that won't heal	___Yes ___No
Open wound or cut	___Yes ___No
Animal or insect bite	___Yes ___No
Blurred vision	___Yes ___No
Sinus congestion	___Yes ___No
Sore throat	___Yes ___No

Earache or discomfort	___Yes ___No
Ear discharge	___Yes ___No
Hoarseness	___Yes ___No
Abdominal pain	___Yes ___No
Decreased appetite	___Yes ___No
Nausea	___Yes ___No
Jaundice	___Yes ___No
Emesis (vomiting)	___Yes ___No
Difficulty swallowing	___Yes ___No
Constipation	___Yes ___No
Blood in stool	___Yes ___No
Burning on urination	___Yes ___No
Blood in urine	___Yes ___No
Foul odor urine	___Yes ___No
Lack of bladder control	___Yes ___No
Increase urine frequency	___Yes ___No
Skin numbness, tingling	___Yes ___No
Breast lump	___Yes ___No
Others	_____

Check (✓) symptoms you currently have or have had in the past 30 days

___Yes ___No Fever
If "yes"; Did you take your temperature with a thermometer? ___Yes ___No
What was the highest temperature reading? _____
How frequent are your fevers? ___Daily ___Every other day ___Once a week ___Other

___Yes ___No Weight loss
if "yes", How many pounds in the past month? _____ In the past 6 months? _____

___Yes ___No Enlarged glands (lymph nodes)
If "yes", Where? _____ For how long? _____

___Yes ___No Headaches
If "yes", ___Daily ___Few times a week ___Rarely
___Severe ___Moderate (relieved with aspirin or Tylenol) ___Mild (resolves on its own)

___Yes ___No Cough
If "yes", Are you bringing up phlegm (sputum)? ___Yes ___No, What color? _____
Do you have pain in your chest when you breath in? ___Yes ___No

___Yes ___No Shortness of breath (difficulty breathing)
If "yes", ___All the time ___Only on exertion ___Rarely ___Other _____

___Yes ___No Diarrhea
If "yes", ___Daily ___Few times a week ___Rarely
How many bouts of diarrhea per day? _____
Consistency of diarrhea: ___Liquid ___Soft ___With blood ___With "mucous"

Male only Check (✓) symptoms you currently have or have had in the past 30 days

___Yes ___No Penis discharge ___Yes ___No Sore on penis
___Yes ___No Sore testicle ___Yes ___No Other _____

Female only Check (✓) symptoms you currently have or have had in the past 30 days

___Yes ___No Vaginal discharge ___Yes ___No Vaginal sore
___Yes ___No Vaginal itching Date of last menstrual period _____
___Yes ___No Are you pregnant? ___Yes ___No Could you be pregnant?

Date of last Pap Smear _____ Results _____ Date of last Mammogram _____ Results _____



To the best of my knowledge, my answers above are correct.

Please sign your name _____ Date _____

h&p form3:rev:7/6/97