Health History Form

Name___________________________
DOB___________________
MR#___________________

Please fill out this history form very carefully. Remember, no detail is too minor. Thank you kindly.

Name (last, first)	Home Phone ( )	Work Phone ( )
Address	Cell Phone ( )	Date of Birth (M/D/Y)
	Email	
City State Zip	Occupation	Marital Status
Place of Birth	How did you hear about us?	Significant Other Name
Indicate preferred non-emergent contact method: email cell phone home phone work phone	Referred by:	
Emergency contact	Emergency phone number	
Preferred Pharmacy Name	Phone Number( )	Fax Number( )

Main Problem(s) you would like to address today:
____
When did this problem begin?____
Interference in daily activities? (work, sleep, sex)____
Have you previously been given a diagnosis for this condition? ______________________________
Previous treatments?____
Last Menstrual Period? ___________ Last Pap Smear? _____________ Last Mammogram? ___________
Last Bone Density Scan? ________________ Last colonoscopy? __________________

Past Medical History: (Please check all that apply and use blanks to include others)

Hypertension	Heart Disease	Asthma	Thyroid	Diabetes
Seizures	Osteoporosis	Cancer	Depression	Anxiety
Endometriosis	Fibroids	Abnormal Pap		

Family History (please use blank areas for other family history not mentioned)

Breast cancer	Ovarian Cancer	Heart Disease	Stroke	Allergies
Asthma	Endometriosis	Depression	Hypertension	Colon Cancer

Surgical History____
Allergies: ____
Medicines (including vitamins, supplements, herbs, drugs with current doses, etc) ____
____
Occupation ______________________________ Have you ever been on a restricted diet? __________
Ever smoke cigarettes?_________. Packs/day_______ For how long?________ Still smoking? ________
Amount of alcohol per week? ________ drinks per week. Have you had difficulty cutting back? ________
Drugs for non-medical purposes?___________________________

Please check all that CURRENTLY apply:

General

Poor appetite	Difficulty falling asleep	Difficulty staying asleep?
Fevers	Chills	Night sweats
Sweat easily	Tremors	Cravings sweets/salts
Bleed/bruise easily	Weight loss	Weight gain
Peculiar tastes/smells	Strong thirst (hot/cold)	Sudden energy drop
Feeling cold?	Feeling Hot?	Fatigue

Skin/Hair

Rashes	Ulcerations	Hives
Itching	Eczema	Pimples
Dandruff	Loss of Hair	Recent moles
Change in hair texture	Change in skin	

Head/Eyes/Ears/Nose/Throat

Dizziness	Migraines	Concussions
Glasses/contact lens	Eye strain	Eye pain
Poor vision	Night blindness	Color blindness
Cataracts	Blurry vision	Earaches
Ringing in ears	Poor hearing	Spots in vision
Sinus Problems	Nose Bleeds	Recurrent sore throat
Grinding teeth	Facial pain	Sores on lips/tongue
Teeth problems	Jaw clicks	Headaches

Cardiovascular

Irregular heart rate	Low blood pressure	Chest pain
Cold hands/feet	Fainting	Blood clots
Swelling of hands	Swelling of feet/ankles	Phlebitis
Difficulty breathing	Varicose veins	Palpitations

Respiratory

Cough	Coughing blood	Bronchitis
Pneumonia	Phlegm (color)	

Gastrointestinal

Nausea	Vomiting	Diarrhea	Constipation
Gas	Belching	Bloody stools	Chronic laxative us
Rectal pain	Hemorrhoids	Abdominal Pain	Abdominal Cramps

Genito-Urinary

Painful urination	Frequent urination	Bloody urine
Urgency to urinate	Night-time urination?	Involuntary loss of urine
Color of urine?	Kidney Stones	Sores on genitals

Reproductive/Gynecologic

Number of Pregnancies?	Number of Births?	Premature Births?
Miscarriages?	**Abortions?**	**Age at first menses?**
Duration of periods?	Bleeding after sex	Bleeding between periods
Cycle length? (28 days?)	Heavy periods	Irregular Periods
Abnormal pap	Painful periods	Vaginal discharge
Vaginal sores	Breast pain	Premenstrual changes
Use of birth control?	What type?	How long?
Menopause (age)	Hot flashes	Decreased desire for sex

Musculoskeletal

Neck pain	Back pain	Knee pain
Back pain	Muscle weakness	Foot/ankle pain
Hand/wrist pain	Shoulder pain	Hip pain

Neuropsychological

Seizures	Loss of Balance	Areas of numbness
Lack of coordination	Poor memory	Concussion
Depression	Anxiety	Bad temper
Easily prone to stress	Insomnia	Vivid dreams

Number of first degree relatives (mother, sisters,daughters) with breast cancer history?_____
Your age when you had your first baby? ______
Have you ever had a breast biopsy? _____ If so, how many? ______
Have you ever been diagnosed with atypical hyperplasia of the breast by biopsy? _________