

Health History Form

Name: _____

Date: _____

Present illness (A brief description of your present complaint) Please print your answers.

Date issue started: _____

Review Of Current Symptoms Check All That Apply

Systemic <input type="checkbox"/> None	<input type="checkbox"/> palpitations	<input type="checkbox"/> Light colored stools	<input type="checkbox"/> urethral discharge	<input type="checkbox"/> impaired balance
<input type="checkbox"/> Weakness	<input type="checkbox"/> lower leg pain	<input type="checkbox"/> BM frequency _____	<input type="checkbox"/> flank pain	<input type="checkbox"/> impaired speech
<input type="checkbox"/> Tiredness	<input type="checkbox"/> Edema (swelling)	<input type="checkbox"/> Mucus in stools	<input type="checkbox"/> genital lesion	<input type="checkbox"/> memory loss
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Chest pressure	<input type="checkbox"/> Rectal pain	<input type="checkbox"/> nocturia (excessive urination at night)	<input type="checkbox"/> seizure
<input type="checkbox"/> Chills	<input type="checkbox"/> Cold extremity (leg/arm)	<input type="checkbox"/> Belching	<input type="checkbox"/> oliguria (decreased production of urine)	
<input type="checkbox"/> Fever	<input type="checkbox"/> diaphoresis (clammy)	<input type="checkbox"/> Diarrhea		PSYCH <input type="checkbox"/> None
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> dyspnea on exertion	<input type="checkbox"/> Constipation	Musculoskeletal <input type="checkbox"/> None	<input type="checkbox"/> depression
<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> reduced exercise tolerance	<input type="checkbox"/> need for antacids	<input type="checkbox"/> arthralgias	<input type="checkbox"/> anxiety
EYES <input type="checkbox"/> None	<input type="checkbox"/> syncope (fainting)	<input type="checkbox"/> Jaundice	<input type="checkbox"/> joint swelling	<input type="checkbox"/> panic attacks
<input type="checkbox"/> Double Vision	<input type="checkbox"/> tachycardia (fast heart rate)	<input type="checkbox"/> coffee ground emesis	<input type="checkbox"/> bone pain	<input type="checkbox"/> suicidal ideation
<input type="checkbox"/> Blurry Vision		<input type="checkbox"/> Dyspepsia (abdominal discomfort)	<input type="checkbox"/> myalgias	<input type="checkbox"/> suicidal planning
<input type="checkbox"/> Yellowing of eyes	Respiratory <input type="checkbox"/> None	<input type="checkbox"/> early satiety (feeling full)	<input type="checkbox"/> back pain	
<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/> Dry cough	<input type="checkbox"/> fecal urgency	<input type="checkbox"/> deformity	ENDO <input type="checkbox"/> None
	<input type="checkbox"/> Productive cough	<input type="checkbox"/> incontinence of stool	<input type="checkbox"/> joint erythema	<input type="checkbox"/> alopecia (hair loss)
ENT <input type="checkbox"/> None	<input type="checkbox"/> Nocturnal cough	<input type="checkbox"/> flatulence (expelling Gas)	<input type="checkbox"/> muscle cramps	<input type="checkbox"/> cold intolerance
<input type="checkbox"/> Hearing difficulty	<input type="checkbox"/> Cough up Blood	<input type="checkbox"/> gas and bloating	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> flushing
<input type="checkbox"/> Ringing In Ears	<input type="checkbox"/> Wheezing	<input type="checkbox"/> hematemesis		<input type="checkbox"/> heat intolerance
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Pleuritic chest pain	<input type="checkbox"/> hemorrhoids	DERMATO <input type="checkbox"/> None	<input type="checkbox"/> polydipsia (excessive thirst)
<input type="checkbox"/> Post Nasal Drip	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> ecchymosis	<input type="checkbox"/> polyphasia (excessive Eating)
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> stridor	<input type="checkbox"/> Loss appetite	<input type="checkbox"/> excessive sweating	<input type="checkbox"/> polyuria (excessive Urination)
<input type="checkbox"/> Voice changes		<input type="checkbox"/> rectal bleeding	<input type="checkbox"/> hair loss	
<input type="checkbox"/> Bleeding Gums	Gastro <input type="checkbox"/> None	<input type="checkbox"/> rectal itching	<input type="checkbox"/> photosensitivity	Hemato/Lymp <input type="checkbox"/> None
<input type="checkbox"/> Mouth Sores	<input type="checkbox"/> anorexia	<input type="checkbox"/> rectal mass	<input type="checkbox"/> pigmentation change	<input type="checkbox"/> easy bruising
<input type="checkbox"/> Globus sensation	<input type="checkbox"/> Nausea	<input type="checkbox"/> tenesmus (feeling of incomplete rectal evacuation)	<input type="checkbox"/> pruritus	<input type="checkbox"/> petechiae (pinpoint flat red Spots)
<input type="checkbox"/> Dental problems	<input type="checkbox"/> Vomiting		<input type="checkbox"/> rash	<input type="checkbox"/> prolonged infection
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> dysphagia (difficulty Swallowing)	GU/Nephro <input type="checkbox"/> None	<input type="checkbox"/> skin change	<input type="checkbox"/> recurrent infections
<input type="checkbox"/> Snoring	<input type="checkbox"/> Heartburn	<input type="checkbox"/> dysuria (painful urination)		<input type="checkbox"/> slow wound healing
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> burning with urination	NEURO <input type="checkbox"/> None	
	<input type="checkbox"/> Abdominal distension	<input type="checkbox"/> blood in urine	<input type="checkbox"/> headache	Allergy/Immuno <input type="checkbox"/> None
Cardio <input type="checkbox"/> None	<input type="checkbox"/> Abdominal mass	<input type="checkbox"/> urinary frequency	<input type="checkbox"/> sleep disturbances	<input type="checkbox"/> hives
<input type="checkbox"/> Chest Pain/Discomfort	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> urinary incontinence	<input type="checkbox"/> numbness	<input type="checkbox"/> oropharyngeal swelling
<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Black stools	<input type="checkbox"/> urinary hesitancy	<input type="checkbox"/> alteration of consciousness	<input type="checkbox"/> throat itching
<input type="checkbox"/> Orthopnea (short of breath when lying down)	<input type="checkbox"/> Red stools	<input type="checkbox"/> change in urine color	<input type="checkbox"/> confusion	<input type="checkbox"/> throat pain

Please print your answers.

Allergies / Reactions Any Food Allergies?

No Yes If yes, please specify:

Surgical History (Please Check All That Apply)

NO PRIOR SURGERY

<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Parathyroid Surg.	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> D&C	<input type="checkbox"/> Orthopedic Surgery
<input type="checkbox"/> Adenoidectomy	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Abdominal Surgery	<input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Spinal Surgery
<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Heart Valve Repair	<input type="checkbox"/> Hernia Repair	<input type="checkbox"/> Cesarean Section	<input type="checkbox"/> Prostate Surgery
<input type="checkbox"/> Sinus Surgery	<input type="checkbox"/> Abdominal Aortic Aneurism	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Ovaries Removed	<input type="checkbox"/>
<input type="checkbox"/> Thyroid Surg.	<input type="checkbox"/> Breast Lumpectomy	<input type="checkbox"/> Gall Bladder Removal	<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Other:				

Personal Medical History

<input type="checkbox"/> Headache/Migraine	<input type="checkbox"/> COPD	<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Anxiety
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Bladder Disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Prostate Disorder	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Heart Disorder	<input type="checkbox"/> Sleep Apnea/Snoring	<input type="checkbox"/> Adrenal Disorder	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> HIV
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Heart Valve Disease	<input type="checkbox"/> Renal Disorders	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Peripheral Vasc Dis.	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Hepatic Disorders	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Recent weight loss	<input type="checkbox"/> Hearing Disorder
<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Pituitary/ Hypothalamic	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Hemophilia	
<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Bleeding problems	
<input type="checkbox"/> Allerg.Rhinitis/Hayfever	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Cancer - Other	<input type="checkbox"/> Brain Tumor	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Reflux	<input type="checkbox"/> Prostate Cancer		
	<input type="checkbox"/> Peptic Ulcer			

Other Medical History

Previous Tests (Include Date) Please obtain reports for your upcoming visit or have them faxed to us (805)777-1730

<input type="checkbox"/> Blood Counts - CBC	<input type="checkbox"/> Colonoscopy: _____	<input type="checkbox"/> Chest X-Ray: _____	<input type="checkbox"/> X-Ray _____
<input type="checkbox"/> Blood Chemistry	<input type="checkbox"/> EKG: _____	<input type="checkbox"/> CT Scan _____	<input type="checkbox"/> Ultrasound _____
<input type="checkbox"/> Fecal Analysis _____	<input type="checkbox"/> Cardio Stress Test: _____	<input type="checkbox"/> MRI Scan _____	<input type="checkbox"/>
<input type="checkbox"/> Cholesterol _____	<input type="checkbox"/>	<input type="checkbox"/>	

Do you take any of the following medications? / Do any of these upset your stomach?

Medication	Dose/Frequency	Reason
<input type="checkbox"/> Aspirin		
<input type="checkbox"/> Ibuprofen/Motrin		
<input type="checkbox"/> Naprosyn/Naproxen		
<input type="checkbox"/> Plavix		
<input type="checkbox"/> Coumadin (warfarin)		

Do you take Antibiotics before surgery or dental work? Yes No

Please print your answers.

Other Medications & Dosages/Frequency (please include all non-prescription medications as well)		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

***Name of your Pharmacy & Location** _____

Marital Status				
<input type="checkbox"/> Single	<input type="checkbox"/> Married, #Yrs: _____	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced

Social History (Check All That Apply)			
<input type="checkbox"/> Y <input type="checkbox"/> N Regular Exercise	<input type="checkbox"/> Y <input type="checkbox"/> N Caffeine Use	<input type="checkbox"/> Y <input type="checkbox"/> N Alcohol Use	<input type="checkbox"/> Present use of Recreational Drug
<input type="checkbox"/> Y <input type="checkbox"/> N Do You Smoke?	# Cups Of Coffee/Day: _____	# Drinks per day: _____ # Drinks per week: _____	<input type="checkbox"/> Past use of Recreational Drug
Cigarette packs per day: _____	# Cups of Tea/Day: _____	Artificial Sweetener use <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/>
<input type="checkbox"/> Y Stopped Smoking? Date: _____	# of Colas/Soda: _____	Milk how many oz's per day: _____	

Family History									
Condition	Mother	Dad	Sisters	Brother	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father	Family History
Alive or Deceased: Age?	<input type="checkbox"/> A _____ <input type="checkbox"/> D _____	<input type="checkbox"/> A _____ <input type="checkbox"/> D _____	<input type="checkbox"/> A _____ <input type="checkbox"/> D _____	<input type="checkbox"/> A _____ <input type="checkbox"/> D _____					
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperlipidemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's ileitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Granulomatous Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cancer	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Uterine Cancer	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancer	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
Other History:	_____ _____ _____								
<input type="checkbox"/> Adopted: Family History Unavailable									