

HEALTH HISTORY

Name: _____ Today's Date: _____
 Age: _____ Birthdate: _____ Date of last physical examination: _____
 Allergies: _____

SYMPTOMS: Check (✓) symptoms you currently have or have had in the past year			
GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN only
<input type="checkbox"/> Chills	<input type="checkbox"/> Appetite poor	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Erection difficulties
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double vision	<input type="checkbox"/> Sore on penis
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Earache	<input type="checkbox"/> Other
<input type="checkbox"/> Headache	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Ear discharge	WOMEN only
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Gas	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Loss of weight	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Numbness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Extreme menstrual pain
<input type="checkbox"/> Sweats	<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Hot flashes
MUSCLE/JOINT/BONE <i>pain, weakness, numbness in:</i>	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Nipple discharge
<input type="checkbox"/> Arms	<input type="checkbox"/> Hips	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Back	<input type="checkbox"/> Legs	<input type="checkbox"/> Vomiting blood	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Feet	<input type="checkbox"/> Neck	CARDIOVASCULAR	<input type="checkbox"/> Vision – Flashes
<input type="checkbox"/> Hands	<input type="checkbox"/> Shoulders	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Vision – Halos
GENITO-URINARY	<input type="checkbox"/> High blood pressure	SKIN	Date of last menstrual period: _____
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Bruise easily	Date of last Pap Smear: _____
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Hives	Have you had a mammogram? _____
<input type="checkbox"/> Lack of bladder control	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Itching	
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Rapid heart beat	<input type="checkbox"/> Change in moles	Are you pregnant? _____
	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Rash	Number of children: _____
	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Scars	
		<input type="checkbox"/> Sore that won't heal	
CONDITIONS: Check (✓) conditions 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
<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