

PATIENT HEALTH HISTORY INFORMATION

Patient Name: MR#

Past Family Medical History

Medication Allergies: _____

Childhood Diseases: Measles Mumps Rubella ChickenPox Other: _____

Please check if you or a family member has had the following:

Personal History	Family History	Disease
		Asthma
		Emphysema
		Cancer of: _____
		Pneumonia
		Bronchitis
		Diabetes
		Hypoglycemia
		Kidney Disease
		High Blood Pressure
		Heart Disease/Attack

Personal History	Family History	Disease
		Stroke
		Ulcers
		Stomach Disorders
		Epilepsy/Convulsive Disorder
		Ear Infection
		Nasal or Sinus Infections
		Bleeding Disorder
		Anesthetic Complications
		Toxic Exposure
		Other: _____

Personal History of:

General:

Skin: Rashes Itching Lesions

Head: Trauma Headache Tenderness Other: _____

Eyes: Vision Changes Glasses(last RX change: _____) Photophobia Blurring
 Spots Inflammation Discharge Other: _____

Nose: Sinus Problems Nose Bleeds Obstruction Polyps Other: _____

Throat: Mouth pain Hoarseness Lesions Dentures Other: _____

Chest: Chest Pain Wheezing Cough Other: _____

Heart: High Blood Pressure Chest pain/tightness Swelling of Ankles

Gastrointestinal: Poor Appetite Difficulty Swallowing Heartburn Stomach Pain Bloating
 Vomiting Blood Diarrhea Constipation Dark Stools Anal Pain Diarrhea

Urinary: Pain on Urination Blood in Urine Nocturia Discharge Impotence

GYN: Last Period (If none, Menopause (Surgical Menopause) Abdominal Pain Spotting
 Use of Contraception Use of Estrogen Last Pelvic Exam Last Pap Smear

Other: Arthritis Anemia Easy Bruising Swollen Lymph Glands Other: _____

Women: Last normal mammogram? _____ Ever used birth control? _____ When? _____
 Ever used hormone replacement therapy? _____ How long? _____ Ever used herbal medications? _____

Social History of:

Marital Status: Single Married Divorced Widow/er Domestic Partner

Current/Past Occupation: _____ **Sexually Active:** Yes No

Ever used Tobacco: Yes No If yes, how many packs a day? _____ For how many years? _____

Alcohol Use: Yes No If yes, how many drinks per day? _____ Per Week? _____

Hospitalizations

Surgeries:

Current Medical Conditions:

List Current Medications:

Are you currently or have you received chemotherapy within the past 90 days? YES NO

Patient's Signature

Date

