Name: _____ Date: _____

HEALTH HISTORY

General
- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Sweats

Eyes
- Crossed eyes
- Double vision
- Vision – Flashes
- Vision – Halos
- Blurred Vision

Ears/Nose/Throat
- Earache
- Ear discharge
- Ringing in ears
- Loss of hearing
- Hay fever
- Sinus problem
- Nose bleeds
- Bleeding gums
- Hoarseness
- Difficulty swallowing
- Persistent cough

Respiratory
- Shortness of breath
- Cough
- Congestion
- Distress
- Sputum

Genito-Urinary
- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful Urination

Endocrine
- Weight gain
- Weight loss
- Hoarseness
- Heat intolerance
- Cold intolerance
- Breast changes
- Hair changes
- Extreme thirst

Gastrointestinal
- Poor appetite
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting no blood
- Vomiting bleeding

Cardiovascular
- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

Integumentary
- Bruise easy
- Hives
- Changes in moles
- Sores not healing
- Itching
- Unusual swelling
- Sores/ulcers
- Rash
- Scars

Neurological
- Seizures
- Vertigo
- Hand trembling
- Loss of sensations
- Loss of facial expression
- Weak grip
- Paralysis
- Difficulty speaking
- Tingling
- Loss of memory
- Numbness

MEN Only
- Breast lumps
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis

WOMEN Only
- Abnormal Pap Smear
- Bleeding btwn periods
- Breast lumps
- Menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other
- Date of last menstrual period _____
- Date of last Pap Smear _____
- Date of last mammogram_____
- Are you pregnant? _____
- Number of children _____

Muscle/Joint/Bone
- Arms
- Hips
- Back
- Legs
- Feet
- Neck
- Hands
- Shoulders

Psychiatric
- Hyperventilation
- Insecurity
- Depression
- Trouble sleeping
- Irritable
- Anxiousness
- Undecidedness
- Timid
- Hallucinations
- Loss of memory
- Alcoholism
- Drug addiction
- Drug dependency
- Extreme worry
- Sexual problems
- Suicidal thoughts

Conditions
- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Asthma
- Bleeding disorders
- Breast lumps
- Bronchitis
- Breath shortness
- Bulimia
- Cancer
- Cataracts
- Chemical dependency
- Chicken pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart disease
- Hepatitis
- Hernia
- Herpes
- High cholesterol
- HIV
- Kidney disease
- Liver disease
- Measles
- Migraines
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pneumonia
- Polio
- Prostate problem
- Rheumatic fever
- Scarlet fever
- Stroke
- Suicide attempt
- Thyroid fever
- Ulcers
- Vaginal infections
- Venereal disease
- Other

MEDICATIONS: List medications you are currently taking

_____
_____
_____
_____
_____

ALLERGIES: List ALL allergies

_____
_____
_____
_____

Patient Signature: _____ _____ **DATE:** _____