Health History Assessment

Name _____ Date _____

Personal Medical History

CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING CONDITIONS:

- Allergies
- Loss of hearing
- Asthma
- Kidney disease
- Prostalitis
- Colitis
- Hepatitus
- Liver disease
- Elevated liver enzyme test
- Pancreatitus
- Ulcer
- Heart attack
- Heart murmur
- Positive stress test
- Heart valve abnormality
- Angina
- Heart failure
- High cholesterol
- High blood pressure
- Arthritis/rheumatism
- Loss of conciousness
- Epilepy
- Convulsions/seizures
- Stroke
- Diabetes
- Thyroid trouble
- Anemia
- Eczema
- Cancer (including skin)
- Sleep apnea

CHECK IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING:

EYES. EARS, NOSE, THROAT

- Difficulty with night vision
- Change in vision
- Blurred or double vision
- Bleeding gums
- Frequent nosebleeds
- Frequent sinus trouble
- Recent hoarseness
- Ringing/buzzing ears
- Earaches

PULMONARY

- Shortness of breath
- Chronic/frequent cough
- Brown/blood-tinged sputum
- Chest tightness
- Wheezing

GENITO-URINARY

- Bladder trouble
- Blood in urine
- Irregular vaginal bleeding
- Currently pregnant
- Difficulty starting/stopping urination
- Urinating 3x per night
- Frequent or painful urination
- Problems with sexual function

GASTROINTESTINAL

- Vomited blood
- Persistent diarrhea
- Persistent constipation
- Frequent abdominal pain
- Frequent nausea
- Frequent indigestion/heartburn
- Black/bloody bowle movement
- Hemorrhoids
- Trouble swallowing
- Hernia

CENTRAL NERVOUS SYSTEM

- Fainting spells
- Recurrent dizziness
- Frequent headaches
- Tremors
- Memory loss
- Loss of coordination
- Difficulty concentrating
- Numbness/tingling extremities

HEART/VASCULAR

- Palpitation (irregular heartbeat)
- Pain or discomfort in chest
- High cholesterol
- Swelling of feet
- Leg pain while walking
- Painful vericose veins

MUSCULOSKELETAL

- Back trouble/pain
- Neck trouble/pain
- Joint injury/pain/swelling
- Carpal tunnel syndrome

MISCELLANEOUS

- Bleeding/bruising easliy
- Enlarged glands
- Rashes
- Unexplained lumps
- Chronic fatigue
- Night sweats
- Undesired weight loss
- Snoring
- Difficulty sleeping
- Low blood sugar

ADDITIONAL HEALTH & LIFESTYLE QUESTIONS:

Have you had any surgical operations over the last 10 years? Y N

Do any diseases run in your family? Y N

Paternal _____ Maternal _____ Age of onset _____

Do you currently have a cough/cold or have you had any in the last 2 weeks? Y N

Have you ever been hospitalized? Y N
If yes, list date, length of stay, and reason: _____

_____

_____

Are you currently under a doctor's care? Y N
If yes, what are you being treated for? _____

_____

_____

Any recent immunizations?

Tetanus _____ Flu _____ Pneumovax _____ Shingles _____

When were your most recent health wellness screening tests?

Cholesterol _____ PSA (Prostate) _____

Mammogram _____ Sigmoidoscopy _____ Pap smear _____

Have you had a change in size or color of a mole, or a sore that would not heal in the past year?
Y N Location _____

Describe any hobbies or recreational activities that have exposed you to noise, chemicals or dust:

_____

_____

Are you experiencing any stresses, mood problems, relationship difficulties, or substance -related problems for which you would like resource or information on a confidential basis? Y N

Do you have any special concerns regarding your health that you would like to discuss? Y N