

HEALTH HISTORY

(Confidential)

Name _____ Today's Date _____

Age _____ Birth date _____

Why are you seeing the doctor? _____

List all medical Problems

Year	Problem

Have you ever had a blood transfusion?

Yes No If Yes, give approximate dates and reason. _____

Women Only

Age of 1st menstrual cycle _____ Age of last menstrual cycle (if post menopausal) _____

Number of pregnancies _____ Age of 1st pregnancy _____

Date of Last Mammogram _____ Date of Last PAP smear _____

Have you had a miscarriage Yes No

Health Habits (If you use and describe how much)

Tobacco Yes/No _____ Alcohol Yes/No _____

Drugs Yes/No _____ Caffeine Yes/No _____

Occupation

Your Occupation _____

Any Exposure History _____

Marital Status

Married Single Widowed Divorced

Fill in Health information on your family.

Relationship	Age	Alive/Dead	Age of Death	Medical Problems

Has anyone in your family had cancer? Yes No If Yes, list who & what type of cancer

Symptoms - Mark (X) symptoms you currently have or have had in the past year.

General

- Weight Loss
- Fevers
- Chills
- Loss of Sleep
- Sweats
- Pain
- Poor Appetite

Eye, Ear, Nose, Throat

- Blurred Vision
- Double Vision
- Bleeding Gums
- Ear Ache
- Ear Discharge
- Hoarseness
- Loss of Hearing
- Nosebleeds
- Ringing in Ears
- Sore Throat
- Mouth Sores

Lymphatics

- Swollen Lymph Glands
- Swelling in Arms/Legs

Musculoskeletal

- Joint Pain
- Muscle Aches

Cardiovascular

- Swelling in Legs
- Chest Pain

- Rapid Heart Beat
- Irregular Heart Beat
- Fainting

Pulmonary

- Shortness of Breath
- Cough
- Coughing Blood
- Wheezing

Gastrointestinal

- Bowel Changes
- Diarrhea
- Constipation
- Blood in Stool
- Nausea
- Vomiting
- Vomiting Blood
- Black Stools
- Stomach Pain
- Rectal Pain
- Difficulty Swallowing

Genito – Urinary

- Blood in Urine
- Frequent Urination
- Lack of Bladder Control
- Painful Urination

Skin

- Bruise Easily
- Hives
- Itching

- Yellowing of Skin
- Rash
- Changes in Moles

Psychological

- Anxiety
- Depression
- Mood Swings
- Chemical Dependency

Neurological

- Headache
- Forgetfulness
- Weakness
- Numbness
- Difficulty with Speech

Men Only

- Breast Lump
- Erection Difficulties
- Lump in Testicle
- Penis Discharge
- Sore on Penis

Women Only

- Abnormal Menstrual Cycles
- Breast Lumps
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____

Date _____

For office use only _____

