

## Health History

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Today's Date	
Age/ Date of Birth	
Reason for visit	

List any medical problems or surgeries you've been diagnosed with or had in the past:	

List your medications (name/dose/frequency)	List any food/drug allergies

Family History	Social History
Mother-	Tobacco
Father-	Alcohol
Sister-	Drugs
Brother-	Occupation
Other-	Stress level (1-10)

Check off any boxes to the left of any symptoms you may have had over the past 6 months:

General	
<input type="checkbox"/>	Chills
<input type="checkbox"/>	Fever
<input type="checkbox"/>	Sweats
<input type="checkbox"/>	Weight Loss
<input type="checkbox"/>	Weight Gain
<input type="checkbox"/>	Forgetfulness
<input type="checkbox"/>	Inability to sleep
<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	Depression
<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Headaches

Skin	
<input type="checkbox"/>	Easy bruising
<input type="checkbox"/>	Hives
<input type="checkbox"/>	Rash
<input type="checkbox"/>	Itching
<input type="checkbox"/>	Scars
<input type="checkbox"/>	Sores
<input type="checkbox"/>	Change in moles

Gastrointestinal	
<input type="checkbox"/>	Decreased Appetite
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Blood in stool
<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Indigestion/ Reflux
<input type="checkbox"/>	Nausea/ Vomiting
<input type="checkbox"/>	Stomach Pain
<input type="checkbox"/>	Gas
<input type="checkbox"/>	Bloating
<input type="checkbox"/>	Vomiting Blood
<input type="checkbox"/>	Excessive hunger
<input type="checkbox"/>	Excessive thirst

Males Only	
<input type="checkbox"/>	Erection difficulties
<input type="checkbox"/>	Lump in testicles
<input type="checkbox"/>	Penis discharge
<input type="checkbox"/>	Sore on penis
<input type="checkbox"/>	Breast lump

Women Only	
<input type="checkbox"/>	Abnormal Pap Smear
<input type="checkbox"/>	Breast lump
<input type="checkbox"/>	Irregular Bleeding
<input type="checkbox"/>	Severe Menstrual Pain
<input type="checkbox"/>	Nipple discharge
<input type="checkbox"/>	Vaginal discharge
<input type="checkbox"/>	Painful intercourse
<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	Last period
<input type="checkbox"/>	Last PAP
<input type="checkbox"/>	Last Mammogram
<input type="checkbox"/>	Are you pregnant

Medical Problems	
<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Psych Disorder
<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	Liver Problems
<input type="checkbox"/>	Stomach Problems
<input type="checkbox"/>	Previous Stroke
<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Thyroid Problems

Genito-Urinary	
<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	Lack of bladder control
<input type="checkbox"/>	Painful urination

Musculoskeletal- pains:		
<input type="checkbox"/>	Arms	Shoulders
<input type="checkbox"/>	Legs	Neck
<input type="checkbox"/>	Back	Hips
<input type="checkbox"/>	Hands	Feet

Cardiovascular	
<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	Irregular Heartbeat
<input type="checkbox"/>	Ankle Swelling
<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>	Poor Circulation

Respiratory	
<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Cough- phlegm
<input type="checkbox"/>	Cough- blood
<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	Hoarseness

Eyes/ Ears/ Nose	
<input type="checkbox"/>	Blurry vision
<input type="checkbox"/>	Double vision
<input type="checkbox"/>	Crossed eyes
<input type="checkbox"/>	Earache
<input type="checkbox"/>	Ear discharge
<input type="checkbox"/>	Poor hearing
<input type="checkbox"/>	Ringings in ears
<input type="checkbox"/>	Use hearing aids
<input type="checkbox"/>	Vision flashes
<input type="checkbox"/>	Vision halos
<input type="checkbox"/>	Dry/Itchy eyes
<input type="checkbox"/>	Eye discharge
<input type="checkbox"/>	Bleeding gums
<input type="checkbox"/>	Swollen glands