

Date: _____

HEALTH HISTORY

This health history form provides us with important information to address your healthcare concerns. Please complete both pages in their entirety with accuracy.

Name: _____ Birthdate: _____/_____/_____
Last First MI Soc. Sec. #

CHIEF COMPLAINTS:

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

ALLERGIES: Yes No If YES, please list all allergies (foods, medications, environment)

MEDICATIONS: Please list all medications you are currently taking. Use additional paper if necessary.

Medication	Dosage	Medication	Dosage

PHARMACY NAME:

PHONE NUMBER: ()

PAST MEDICAL HISTORY: Have you ever had or do you have the following? Circle "no" or "yes." Leave blank if uncertain.

Alcoholism	yes	no	High Blood Pressure	yes	no	Other Conditions (Please List) 1. _____ 2. _____ 3. _____ 4. _____
Anemia	yes	no	High Cholesterol	yes	no	
Arthritis	yes	no	HIV	yes	no	
Asthma	yes	no	Kidney Disease	yes	no	
Cancer	yes	no	Liver Disease	yes	no	
Diabetes	yes	no	Severe Headaches	yes	no	
Epilepsy	yes	no	Stroke	yes	no	
Gout	yes	no	Syphillis	yes	no	
Heart Trouble	yes	no	Tuberculosis	yes	no	
Hepatitis	yes	no				

HOSPITALIZATIONS: (Include Dates)

1. _____
 2. _____
 3. _____
 4. _____

SURGERIES: (List surgeon and approximate date)

1. _____
 2. _____
 3. _____
 4. _____

SOCIAL HISTORY:

Caffeine Intake:

None Yes: Amount/wk: _____

Do you drink alcohol?

No Yes: # drinks/wk: _____

Tobacco Use:

Never Quit Yes: Amount/wk: _____

Do you use any recreational drugs?

No Yes

FAMILY HISTORY: *Do any blood relatives have the following major health problems? Who?*

Arthritis _____

Chemical Dependency _____

Kidney Disease _____

Asthma _____

Diabetes _____

Stroke _____

Cancer _____

Heart Disease _____

Tuberculosis _____

Type: _____

High Blood Pressure _____

Other _____

SYMPTOMS: *Place a 4 beside symptoms you currently have or have had in the past year.*

Chills

Fever

Sweats

Weight Loss

Blurred vision

Earache

Hearing Loss

Ringing in ears

Sinus problems

Nosebleeds

Chest pain

Poor circulation

Varicose veins

Chronic cough

Shortness of

Breath

Nausea

Vomiting

Diarrhea

Indigestion

Bowel change

Rectal Bleeding

Stomach Pain

Swallow Difficulty

Blood in urine

Frequent urination

Painful urination

Joint pain

Joint swelling

Easy bruising

Numbness

Weakness

Headache

Convulsions

Dizziness

Memory Loss

Anxiety

Depression

Loss of sleep

Hives

Itching

Rashes

New Lesions

Breast Lump

Other _____

Other _____

MEN ONLY

Erection Difficulty

Lump in testicles

Penis Discharge

Sore on penis

WOMEN ONLY

Abnormal Pap Smear

Menstrual Irregularity

Hot flashes

Nipple discharge

Date of Last

Period _____

Are you pregnant?

No Yes

Pregnancies _____

Deliveries _____

Complications (if any)

SIGNATURE

I certify the above information is accurate and complete to the best of my knowledge. I will not hold ID Consultants, PA, its officers, directors, employees, or my physician responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Date

Reviewed By

Date