Confidential Health History

Patient Name: ______________________ **Today's Date:** ______________

Reason for this visit? ______________________

How long have symptoms been present? ______________________

Symptoms (check symptoms you currently have or have had)

GENERAL

- ❑ Blackouts
- ❑ Can't stay awake
- ❑ Confusion
- ❑ Convulsions
- ❑ Coordination Difficulty
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Headache
- ❑ Loss of sleep
- ❑ Memory loss
- ❑ Numbness/Tingling
- ❑ Poor Appetite
- ❑ Sweats
- ❑ Weight gain
- ❑ Weight loss

MUSCLE/JOINT/BONE

Pain/Numbness

- ❑ Arms
- ❑ Hips
- ❑ Back
- ❑ Legs
- ❑ Feet
- ❑ Neck
- ❑ Hands
- ❑ Shoulders

CARDIOVASCULAR

- ❑ Chest Pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling in ankles

URINARY

- ❑ Frequent urination
- ❑ Incontinence
- ❑ Painful urination

EYE/EAR/NOSE/THROAT

- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nose bleeds
- ❑ Persistent cough
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Vision - Flashes - Halos

SKIN

- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Rash
- ❑ Scars
- ❑ Sores that won't heal

SEXUAL DIFFICULTIES

- ❑ Erection difficulties
- ❑ Other ______________

WOMEN ONLY

Date of last period: ______________

Have you ever had a mammogram? ______________

If yes, when: ______________

Are you pregnant? __________ Number of Children: __________

Conditions (Check conditions you currently have or have had)

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sicklecell Anemia
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Syphilis
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers

Diagnostic Related Issues

Pacemaker ❑ YES ❑ NO When? ______________

Stints ❑ YES ❑ NO Location? ______________

Metal Implants ❑ YES ❑ NO Location? ______________

Allergic to Contrast (IV Dye) ❑ YES ❑ NO

Allergic to Iodine ❑ YES ❑ NO

Family History

Relation	Age	State of Health	Age of Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of the following neurological disorders or medical disorders:

Relationship to you:

- ❑ Alzheimer's Disease
- ❑ Dementia
- ❑ Epilepsy
- ❑ Gait Problems
- ❑ Muscle Disorders
- ❑ Neuropathy
- ❑ Parkinson's Disease
- ❑ Tremors
- ❑ Other Neurological Disease
- ❑ Other Medical Disease

Health Habits	Occupational:
Check (✔) which you use and how much you use.	**Check (✔) if your work exposes you to:**
❑ Caffeine____________ ❑ Tobacco____________ ❑ Alcohol____________	❑ Stress ❑ Heavy Lifting ❑ Hazardous Substances
❑ Street Drugs____________	❑ Other ____________

List Of Medications

Hospitalization/Inpatient & Outpatient Surgical Procedures

Year	Hospital	Reason for Hospitalization and Outcome

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative ____________ Date ____________

Please print name of Patient, Parent, Guardian or Personal Representative ____________ Relationship to Patient ____________

Reviewed By ____________ Date ____________

Please List Any Drug Allergies

Drug: ____________ Reaction: ____________

Drug: ____________ Reaction: ____________

Drug: ____________ Reaction: ____________

Drug: ____________ Reaction: ____________

Drug: ____________ Reaction: ____________