HEALTH HISTORY
(Confidential)

NAME _____ **DATE** _____

DOB _____ **AGE** _____ **LAST AWV** _____

PRESCRIPTIONS
Please list any medications that are prescribed for you by a medical provider.

Drug: _____ *Dose:* _____ *# / Day:* _____ *Started:* _____

Drug: _____ *Dose:* _____ *# / Day:* _____ *Started:* _____

Drug: _____ *Dose:* _____ *# / Day:* _____ *Started:* _____

Drug: _____ *Dose:* _____ *# / Day:* _____ *Started:* _____

OTC MEDICATIONS
Please list any over-the-counter (OTC) medications you are currently taking.

Drug: _____ *Dose:* _____ *# / Day:* _____ *Started:* _____

Drug: _____ *Dose:* _____ *# / Day:* _____ *Started:* _____

ALLERGIES
Please describe any allergies you may have.

Drugs: _____ *Foods:* _____

Outdoors: _____ *Other:* _____

SYMPTOMS
Please check symptoms you currently have or have had in the past year.

General
- ☐ Depression
- ☐ Dizziness / Fainting
- ☐ Fever / Chills
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle / Joint / Bone
Pain or numbness in:

- ☐ Arms / Hands
- ☐ Hips
- ☐ Back
- ☐ Legs / Feet
- ☐ Neck
- ☐ Shoulders

Genito-Urinary
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

Gastro
- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Cardiovascular
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure

Eye, Ear, Nose, & Throat
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache / Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Snoring
- ☐ Vision Flashes / Halos

Reproductive Health
- ☐ Abnormal Pap Smear
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Erection Difficulties
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Lump in Testicles
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Vaginal Discharge
- ☐ Other _____

Skin
- ☐ Bruise Easily
- ☐ Hives
- ☐ Rash / Itching
- ☐ Change in Moles
- ☐ Scars
- ☐ Sores That Won't Heal

SUBSTANCES
Please describe any substances you use and how much you use them.

Caffeine: _____ *Recreational Drugs:* _____

Tobacco: _____ *Other:* _____

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SPECIALISTS
Please provide the month/year of your last specialist visits, as applicable.

Cardiology	_____	Gastro	_____	Oncology	_____	Pulmonary	_____
Dermatology	_____	Hematology	_____	Orthopedics	_____	Rheumatology	_____
Endocrinology	_____	Nephrology	_____	Physical Therapy	_____	Sleep Study	_____
ENT	_____	OBGYN	_____	Psychiatry	_____	Urology	_____

Have you had a DENTAL check-up in the past year? ☐ Yes ☐ No

Have you had a VISION check-up in the past year? ☐ Yes ☐ No

Have you had a MAMMOGRAM in the past year? ☐ Yes ☐ No

FAMILY HISTORY
Please list any relevant health information from your family, specifically:

Arthritis, Asthma, Cancer, Chemical Dependency, Diabetes, Gout, Heart Disease, High BP, Kidney Disease, or Tuberculosis.

Father *Age:* _____ *Health Problems:* _____

Mother *Age:* _____ *Health Problems:* _____

Sibling(s) *Age(s):* _____ *Health Problems:* _____

Other *Age(s):* _____ *Health Problems:* _____

CONDITIONS
Please check any conditions that you have ever had in your life.

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

SERIOUS ILLNESS
Please describe any major health problems or events you have experienced.

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

HOSPITAL HISTORY
Please describe and date any events that caused you to be hospitalized.

Year _____ Outcome _____

Year _____ Outcome _____

Year _____ Outcome _____

PREGNANCY HISTORY
Please describe and date events related to pregnancy.

Year _____ Gender _____ Complications, if any: _____

Year _____ Gender _____ Complications, if any: _____

Year _____ Gender _____ Complications, if any: _____