PATIENT NAME: ______________________________ DATE OF BIRTH: ____________________

HEALTH HISTORY

HEALTH MAINTENANCE	DATE		DATE		DATE
Bone Density		Flu Vaccine		Physical Exam-Routine	
Chicken Pox Vaccine		Foot Exam		Pneumovax	
Colonoscopy		Health Proxy/Living Will		PPD	
Dental Exam		Mammogram		Sigmoidoscopy	
Eye Exam		Pap Smear		Stress Test	

MEDICAL PROBLEMS					
	Abdominal Discomfort		Difficulty Urinating		Nausea
	Alcohol Abuse		Drug Abuse		Palpitations
	Anemia		Fever of Unknown Origin		Persistent Cough
	Anxiety		Frequent Urination		Pneumonia
	Arthritis		Gall Bladder Disease		Rheumatic Fever
	Asthma		Gout		Shortness of Breath
	Blood in Stool		Hay Fever		Swollen Ankles
	Bronchitis		Headache		Thyroid Disease
	Cancer		Heart Disease		Tuberculosis
	Change in Bowel Habits		Hemorrhoids		Ulcers
	Chest Pain/Tightness		Hepatitis		Venereal Disease
	Chills/Night Sweats		High Blood Pressure		Vomiting
	Colitis		Indigestion		Weight Gain
	Constipation		Jaundice		Weight Loss
	Coughing Up Blood		Kidney Disease		Other:
	Depression		Kidney Stones		
	Diabetes		Loss of Appetite		
	Diarrhea		Low Back Problems		

ACCIDENTS/INJURIES

Accident/Injury	Year	Outcome

HOSPITALIZATIONS

Reason for Hospitalization	Year	Hospital	Outcome

PATIENT NAME: ________________________________ **DATE OF BIRTH:** ____________________

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING AND THE DOSAGE IF KNOWN			
Drug Name	**Dosage**	**Drug Name**	**Dosage**

LIST ALLERGIES	
Drug Allergies	**Other/Seasonal Allergies**

SOCIAL/PERSONAL HISTORY				
Do you smoke?		No		Yes; How much?:
Do you drink alcohol?		No		Yes; How much?:
Do you use recreational drugs?		No		Yes; How much?:
Do you consume caffeine?		No		Yes; How much?:

	FAMILY MEDICAL HISTORY -Check Box(s) for Yes										
	Father	Mother	Brother 1	Brother 2	Sister 1	Sister 2	Blood Relatives-indicate relationship in box at top of column				
Cancer											
Diabetes											
Heart Disease											
Hypertension											
Kidney Disease											
Mental Illness											
Stroke											
Other (Specify)											

PATIENT NAME: ______________________________ **DATE OF BIRTH:** ____________________

REVIEW OF SYSTEMS – please check all that apply

	CONSTITUTIONAL SYMPTOMS		GASTROINTESTINAL
	Chills		Change in Bowel Habits
	Fainting		Diarrhea
	Fever		Nausea
	Sleep Disorder		Vomiting
	Sweats		
	Weight Loss		**GENITOURINARY**
			Frequent Urination
	EYES		Hematuria
	Flashing Lights		Incontinence
	Glare/Light Sensitivity		Sexual Difficulties
	Double Vision		Pain on Urination
	EARS, NOSE, MOUTH & THROAT		**MUSCULOSKELETAL**
	Earache		Numbness
	Hearing Loss		Pain
	Ringing in Ears		Weakness
	Bloody Nose		
	Other Nasal Symptoms:		**SKIN**
	Hoarseness		Mole Changes
	Swallowing Difficulty		Rashes
	CARDIOVASCULAR		**NEUROLOGICAL**
	Chest Pain		Dizziness
	Palpitations		Headache
	Irregular Heartbeat		Memory Lapses
	Swelling of Ankles		Numbness
	RESPIRATORY		**PSYCHIATRIC**
	Cough		Depression
	Coughing up Blood		Nervousness
	Shortness of Breath		

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

______________________________ **Date:** ____________________
Patients Signature or parent if minor

Physicians Signature: ______________________________