HEALTH HISTORY FORM

(All information will remain confidential)

Name _____ Today's Date: _____

Age _____ Date of Birth _____ Sex _____

Reason for Visit _____ Weight _____ Height _____

PAST MEDICAL HISTORY (Check items where previous history applies)

____	Benign Prostate Hyperplasia	____	Degenerative Disc Disease	____	Kidney Stone
____	Cancer, Type _____	____	Osteoporosis	____	Heartburn (GERD)
____	Atrial Fibrillation	____	Diabetes Mellitus	____	Hiatal Hernia
____	Congestive Heart Failure	____	Diabetic Neuropathy	____	Cataracts
____	Heart Murmur	____	Migraine Headaches	____	Sleep Apnea
____	High Blood Pressure	____	Hyperthyroidism	____	Asthma
____	High Cholesterol	____	Hypothyroidism	____	COPD
____	Previous Heart Attack	____	Wound Infection Post Surgery	____	HIV/AIDS
____	Stroke	____	End Stage Renal Disease		

List Other Conditions Here:

_____

PAST SURGICAL HISTORY (Please check or list all previous operations; Insert year adjacent to operation.)

____	Adenoidectomy	____	Heart Valve Replacement	____	PE Tubes in Ears
____	Appendectomy	____	Hip Replacement	____	Prostate Surgery
____	Back Surgery	____	Hysterectomy	____	Septoplasty
____	Cardiac Stents	____	Inguinal Hernia	____	Sinus Surgery
____	Cataract Surgery	____	Knee Surgery	____	Thyroidectomy
____	C-Section	____	Lithotripsy	____	Tonsillectomy
____	Cholecystectomy	____	Lung Resection	____	Tubal Ligation
____	Coronary Artery Bypass	____	Neck Surgery	____	Umbilical Hernia
____	Ear Surgery	____	Pacemaker/ Defibrillator		

List Other Surgeries Here:

_____

MEDICATION LIST

List all CURRENT prescription and over-the-counter (non-prescription) medications such as vitamins, Aspirin, Tylenol, and herbal (ex: Ginseng, Gingko Biloba, St. John's Wort). Include prescriptions taken as needed. (ex: Viagra, Nitroglycerin)

NAME OF MEDICATION	DOSE	HOW OFTEN DO YOU TAKE?	REASON FOR MEDICATION?

(Please see reverse side for Page 2)

DRUG ALLERGY LIST Please check/list all medications or vaccinations that have caused an allergic reaction in the past:
___ Penicillin ___ Sulfa Drugs ___ IV/Dye ____ Codeine ____ No Known Drug Allergies
___ Other, Please List:

LATEX ALLERGY? Are you allergic to latex? ____ Yes ____ No
ANESTHESIA PROBLEMS? Have you had any previous difficulties with general anesthesia or sedation? ____ Yes ___ No
If yes, please provide details below:

PREGNANCY? Are you currently pregnant? ____ Yes ____ No ____ Possibly

*ALL INFORMATION IS IMPORTANT*PLEASE COMPLETE ALL SECTIONS*

FAMILY HISTORY Check if any of your relatives have had any of the following conditions:

	Indicate Relationship to You (Maternal or Paternal)		Indicate Relationship To You
___ Stroke		**___ Ischemic Heart Disease**	
___ Breast Cancer		**___ Kidney Disease**	
___ Colon Cancer		**___ Ovarian Cancer**	
___ Diabetes Mellitus		**___ Thyroid Cancer**	
___ Other		**___ Other**	
___ Other		**___ Other**	

SOCIAL HISTORY Check which substances you use and how much you use:

___ Alcohol, never	___ Tobacco, never	___ Tobacco, current unknown	Age Started: ____
___ Alcohol, moderate use	___ Tobacco, current everyday	___ Tobacco, unknown	Age Stop: ____
___ Alcohol, heavy use	___ Tobacco, current some days	___ Tobacco, heavy	ScreeningDate:
___ Alcohol, rare use	___ Tobacco, former smoker ____ Yrs	___ Tobacco, light	___/___/___

REVIEW OF SYSTEMS Check symptoms you **CURRENTLY** have or **ARE ASSOCIATED WITH THE REASON FOR YOUR VISIT.**

Constitutional
__ Fever
__ Loss of Appetite
__ Weight Loss

Eyes
__ Double Vision
__ Blurred Vision
__ Eye Discomfort

Cardiovascular
__ Rapid Heart Rate
__ Dyspnea/Exertion
__ Chest Pain

Respiratory
__ Wheezing
__ Cough
__ Shortness of Breath

Gastrointestinal
__ Vomiting
__ Heartburn
__ Difficulty Swallowing

Genitourinary
__ Enuresis (bed wetting)
Indicate Frequency_____

Skin
__ Rash
__ Itchy Skin
__ Dry Skin

Neurology
__ Seizures
__ Loss of Balance
__ Memory Difficulties

Musculoskeletal
__ Joint Pain
__ Limitation of Motion
__ Joint Swelling

Endocrine
__ Weight Gain
__ Cold Intolerance
__ Loss of Hair

Psychiatric
__ Anxiety
__ Depression
__ Difficulty Sleeping

Heme-Lymph
__ Easy Bleeding (following injury)
__ Easy Bruising

Allergy
__ Sinus Allergy Symptoms
__ Allergic Dermatitis

ENT

Ear
__ Pain
__ Hearing Loss (__Right/__Left)
__ Noise in Ear(s) __Ringing/__Other
__ Drainage
__ Pressure
__ Dizziness (__Spinning/__Light-Headed)

Nose
__ Congested
__ Discharge (__Clear/__Thick/__Colored)
__ Postnasal Drip
__ Snoring (___Apnea)
__ Nosebleeds

Throat
__Hoarseness
__ Throat Clearing
__Lump In Throat
__Sore Throat

Sinus
__Facial Pressure /__ Facial Pain /__Frequent Sinusitis