

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	URINARY	WOMEN ONLY			
<input type="checkbox"/> Blackouts <input type="checkbox"/> Can't stay awake <input type="checkbox"/> Confusion <input type="checkbox"/> Convulsions <input type="checkbox"/> Coordination Difficulty <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Memory loss <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Sweats <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss	<input type="checkbox"/> Frequent urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Painful urination <div style="background-color: #cccccc; text-align: center; font-weight: bold; padding: 2px;">EYE/EAR/NOSE/THROAT</div> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes - Halos	Date of last period: _____ Have you ever had a mammogram? _____ If yes, when: _____ Are you pregnant? _____ Number of Children: _____ <div style="background-color: black; color: white; text-align: center; font-weight: bold; padding: 2px;">Conditions (Check conditions you currently have or have had)</div> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes </td> <td style="width: 50%; border: none; vertical-align: top;"> <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Sicklecell Anemia <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Syphilis <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers </td> </tr> </table>		<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Sicklecell Anemia <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Syphilis <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers
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MUSCLE/JOINT/BONE	SKIN				
<div style="background-color: #cccccc; text-align: center; font-weight: bold; padding: 2px;">Pain/Numbness</div> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sores that won't heal				
CARDIOVASCULAR	SEXUAL DIFFICULTIES				
<input type="checkbox"/> Chest Pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling in ankles	<input type="checkbox"/> Erection difficulties <input type="checkbox"/> Other _____ _____ _____ _____				

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	Check if your blood relatives had any of the following neurological disorders or medical disorders:
Father					Relationship to you:
Mother					<input type="checkbox"/> Alzheimer's Disease
Brothers					<input type="checkbox"/> Dementia
					<input type="checkbox"/> Epilepsy
					<input type="checkbox"/> Gait Problems
					<input type="checkbox"/> Muscle Disorders
					<input type="checkbox"/> Neuropathy
Sisters					<input type="checkbox"/> Parkinson's Disease
					<input type="checkbox"/> Tremors
					<input type="checkbox"/> Other Neurological Disease
					<input type="checkbox"/> Other Medical Disease

Health Habits**Occupational:****Check (✓) which you use and how much you use.**
 Caffeine _____ Tobacco _____ Alcohol _____
 Street Drugs _____
Check (✓) if your work exposes you to:
 Stress Heavy Lifting Hazardous Substances
 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