Medical Office Health History Form

Date: ____________________ **Name:**____

Age:______ **Date of birth:**________________________________ **Sex:** **M** **F** **NB** __________

Occupation: ____

Patient's Primary Complaint: ____

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Medications (List all medications you are currently taking.)	**Allergies** (List all allergies)

Patient's Past History:

Do you have or have you ever had the following? Check each box that is answered "yes".

- ☐ Rashes or hives
- ☐ Headaches, dizziness, fainting
- ☐ Blurred vision
- ☐ Hearing loss
- ☐ Sinus trouble
- ☐ Asthma
- ☐ Sore throats
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Night sweats
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Rheumatic fever
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heartburn or indigestion
- ☐ Nausea and/or vomiting
- ☐ Peptic ulcer
- ☐ Rectal bleeding, hemorrhoids
- ☐ Sudden weight gain or loss
- ☐ Kidney disease or stones
- ☐ Painful and/or difficult urination
- ☐ Diabetes
- ☐ Sexually transmitted disease
- ☐ Become tired or upset easily
- ☐ Depression
- ☐ Convulsions
- ☐ Back pain or injury

**Please use the space below to explain any "yes" answers.*

Serious Illness/Injuries/Hospitalizations	**Date**	**Outcome**

Patient's Family and Social History:

	Yes	No	Quantity/Frequency
Do you use tobacco?	( )	( )	______________________________
Do you use drugs?	( )	( )	______________________________
Do you use alcohol?	( )	( )	______________________________
Do you exercise regularly?	( )	( )	______________________________

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Relation	Age	State of Health	Serious Illness and/or Cause of Death
Father			
Mother			
Brother			
Sister			

Review of Symptoms: Please check each item "Yes" of "No" as they relate to you.

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain >10 pounds
- ☐ Weight Loss >10 pounds

SKIN
- ☐ Nail Changes
- ☐ New Lesions
- ☐ Rash
- ☐ Skin Color Changes

HEENT
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Eye Redness
- ☐ Decreased Hearing
- ☐ Earache
- ☐ Ear Ringing
- ☐ Nose Bleeds
- ☐ Dry Mouth
- ☐ Hoarseness
- ☐ Oral Ulcers
- ☐ Sore Throat

NECK
- ☐ Neck Pain
- ☐ Swollen Glands

RESPIRATORY
- ☐ Chronic Cough
- ☐ Decreased Exercise Tolerance
- ☐ Difficulty Breathing
- ☐ Coughing Up Blood
- ☐ Sputum Production
- ☐ Wheezing

BREAST
- ☐ Breast Mass
- ☐ Breast Pain
- ☐ Nipple Discharge
- ☐ Skin Changes

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Leg Pains with walking
- ☐ Leg Swelling
- ☐ Night Awakening due to trouble Breathing
- ☐ Palpitations
- ☐ Shortness of Breath

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Trouble Swallowing

GENITOURINARY
- ☐ Vaginal Discharge
- ☐ Menstrual Irregularities
- ☐ Difficulty Starting/Stopping urinary Stream
- ☐ Painful Urination
- ☐ Change in Urinary Stream
- ☐ Increased Frequency
- ☐ Blood in Urine
- ☐ Loss of Bladder Control
- ☐ Nighttime Urination
- ☐ Urinary Retention
- ☐ Urethral Discharge
- ☐ Impotence
- ☐ Penile Lesions
- ☐ Testicular Mass
- ☐ Testicular Pain

MUSCULOSKELETAL
- ☐ Decreased Range of Motion
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Wasting
- ☐ Muscle Weakness
- ☐ Muscle Aches/Pains

NEUROLOGICAL
- ☐ Loss of Bowel Control
- ☐ Dizziness/Vertigo
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Passing Out
- ☐ Seizures
- ☐ Tremor

PSYCHIATRIC
- ☐ Anxiety
- ☐ Change in Sleep Pattern
- ☐ Depression
- ☐ Hallucinations
- ☐ Suicidal Thoughts

ENDOCRINE
- ☐ Appetite Changes
- ☐ Cold Intolerance
- ☐ Increased Thirst
- ☐ Increased Urination
- ☐ Hair Changes
- ☐ Sexual Dysfunction

HEMATOLOGY
- ☐ Easy Bruising
- ☐ Enlarged Lymph Nodes
- ☐ Prolonged Bleeding

Additional Information: Please answer the ones that apply to your health:

Last Mammogram____________ Where? ________________ Last Pap? _________________ Last Gyn? __________

Leading MDs to perform future pap? Yes No

Last Colonoscopy? ______________ Normal ? ________________ Dr? ____________ Repeat Date ? ___________

Approximate Date of last Bloodwork? _______________________ Last Rectal (Over 50 y/o)? _________________

Vaccines Dates: Tetanus____________ Pneumonia__________ Flu______________ Hepatitis B________________