**Add logo here**  
  
**Health History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Last name:** |  | **First name:** |  | **DOB:** |  |

**Reason for your visit today:**

|  |
| --- |
|  |
|  |
|  |

**Personal Medical History**

**Constitutional** *e.g., fever, heat stroke, weight loss, weight gain, unusually tired, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Ear/Nose/Throat** *e.g., hard of hearing, stuffy nose, earache, cough, dry mouth, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Heart (Cardiovascular)** *e.g., high blood pressure, racing pulse, chest pain, unable to exercise, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Lungs (Respiratory)** *e.g., congestion, wheezing, shortness of breath, productive or bloody cough, asthma, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Digestion (Gastrointestinal)** *e.g., stomach upset, diarrhea, constipation, hernia, ulcers, pain/cramps, acid reflux, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Muscles and bones (Musculoskeletal)** *e.g., muscle pain/cramps, joint pain swelling, stiffness, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Urological** *e.g., painful or frequent urination, burning, impotence, incontinence, infections, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Gynecological** *e.g., pregnancies, menstrual problems, ovarian and uterine conditions, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Breast** *e.g., cysts, fibroids, pain, numbness, lumps, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

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**Neurological** *e.g., numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Psychiatric** *e.g., depression, anxiety, mood swings, insomnia, hallucinations, disorientation, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Blood/Lymphatic** *e.g., high cholesterol, anemia, blood disorders, leukemia, prolonged bleeding, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Skin** *e.g., itching, rash, infection, ulcer, tumors or growths, warts, excessive dryness, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Cancer**

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Allergic/Immunologic** *e.g., recurrent infections, hay fever, food allergy, drug sensitivity, hives, redness, itching, etc*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Hormones (Endocrine)** *e.g., diabetes, thyroid problems, fatigue, hair loss, hot/cold intolerance, etc.*

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**IF DIABETIC:**

|  |  |
| --- | --- |
| **Doctor and contact information:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Year of diagnosis:** |  | **Result/Time of last blood sugar:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Last hemoglobin A1C:** |  | **Treatments:** |  |

**Major illnesses/Hospitalizations**

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

**Surgeries**

Yes  No

|  |  |
| --- | --- |
| Comments: |  |

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**Family History**  
*(Parents, Siblings, or Grandparents only)*

|  |  |
| --- | --- |
| **[Insert specific history relevant to your specialty]** | |
|  |  |
| **Systemic Disease** | |
| Diabetes  Cancer  Heart disease | Hypertension  Arthritis  Other: |

**PERSONAL SOCIAL HISTORY**

|  |  |
| --- | --- |
| **Marital status:** |  |

|  |  |
| --- | --- |
| **Living arrangements:** |  |

**Have you been exposed to venereal disease/sexually transmitted infection?**

Yes  No

**Are you pregnant?**

Yes  No

|  |  |
| --- | --- |
| **Occupation(s):** |  |

**Occupational exposure:**

Yes  No

**Recent travel:**

Yes  No

**Tobacco use**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Never | Current everyday use | Current intermittent use | Former use | Status unknown | Other: |  |

**Alcohol use**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Never | Current everyday use | Current intermittent use | Former use | Status unknown | Other: |  |

**Recreational drug use**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Never | Current everyday use | Current intermittent use | Former use | Status unknown | Other: |  |

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**Medications:** *List ALL medications you are CURRENTLY taking. (Include all herbals, vitamins and supplements)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Dose** | **Frequency** | **Other information** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**IF MEDICATION LIST GOES BEYOND THE SPACE PROVIDED, THEN PLEASE ATTACH A SEPARATE SHEET**

**Allergies:** Please list ALL allergies

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergy** | **Severity** | **Reaction** | **Treatment Information** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Preferred pharmacy:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Pharmacy Location Number** | **Address** | **Phone Number** | **Fax Number** |
|  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature** |  | **Date** |  |

|  |  |
| --- | --- |
| **Printed name** |  |

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