Health & Medical History Form

Name ____

Birth date ____

Family Physician and/or Primary Health Care Provider:

Doctor/Other ______________________ Phone ______________________

Address ______________________ City ________________ Zip_______

May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

o Yes o No Signature: ______________________________ Date:____________

Present Medical History

Check those questions to which you answer yes (leave the others blank).

___ Chills
___ Depression
___ Dizziness
___ Fainting
___ Forgetfulness
___Headache
___ Loss of Sleep
___ Loss of Weight
___ Numbness
___Sweats
___ Scars
___ Blood in urine

___Appetite Poor
___ Bloating
___ Bowel changes
___ Constipation
___ Diarrhea
___ Excessive hunger
___ Excessive thirst
___ Gas
___Hemorrhoids
___Indigestion
___ Rash
___ Frequent urination

___ Nausea
___ Rectal bleeding
___ Stomach pain
___ Vomiting blood
___ Bleeding gums
___ Blurred vision
___ Crossed eyes
___ Difficulty swallowing
___ Double vision
___ Earache
___ Hives
___ Painful urination

___ Ear discharge
___ Hay fever
___ Hoarseness
___ Loss of Hearing
___ Nosebleeds
___ Persistent cough
___ Ringing in ears
___ Sinus problems
___ Vision – Flashes
___ Vision – Halos
___ Itching
___ Lack of bladder control

___ Chest pain
___ High blood pressure
___ Irregular heart beat
___Low blood pressure
___ Poor circulation
___ Rapid heart beat
___ Swelling of ankles
___Varicose veins
___Bruise easily
___Sore that won't heal
___ Change in moles

Do you now have or have you recently experienced:

Muscle/Joint/Bone: Pain, weakness, numbness in: __ Hands ___Arms __Feet __ Legs __Hips __Back __Neck __Shoulders
Comments:____
____
____

Men only answer the following. Do you have:

___ Breast Lump ___ Erection difficulties___ Lump in testicles___ Penis discharge___ Sore on penis___ Other

Women only answer the following. Do you have:

___ Abnormal Pap Smear ___ Bleeding between periods ___ Breast Lump ___ Extreme menstrual pain ___ Hot flashes ___ Nipple discharge
___ Painful intercourse ___ Vaginal discharge ___ Other

Have you had a mammogram? Yes or No (Circle one) Abnormal or Normal (Circle one)

Are you pregnant? Yes or No (Circle one) Number of Children? _____________

Are you on any type of hormone replacement therapy? ______________________________________

Men and women answer the following:

List any prescription medications you are now taking: ______________________________________

List any self-prescribed medications, dietary supplements, or vitamins you are now taking:______________________

Date of last complete physical examination: ______________________________________

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Conditions

Check those questions to which your answer is yes (leave others blank).

___ Aids ___ Alcoholism ___ Anemia ___ Anorexia ___ Appendicitis ___ Arthritis ___Asthma ___ Bleeding Disorders ___ Breast Lumps

___ Bronchitis ___ Bulimia ___ Cancer ___ Cataracts ___ Chemical Dependency ___ Chicken Pox ___ Diabetes ___ Emphysema ___ Epilepsy

___ Glaucoma ___ Goiter ___ Gonorrhea ___ Heart Disease ___ Hepatitis ___ Hernia ___ Herpes ___ High Cholesterol ___ HIV Positive

___ Kidney Disease ___ Liver Disease ___ Measles ___ Migraine Headaches ___ Miscarriage ___ Mononucleosis ___ Multiple Sclerosis

___ Mumps ___ Pacemaker ___ Pneumonia ___ Polio ___ Prostate Problem ___ Psychiatric Care ___ Rheumatic Fever ___ Scarlet Fever

___ Stroke ___ Suicide Attempt ___ Thyroid Problems ___ Tonsillitis ___ Tuberculosis ___ Typhoid Fever ___ Ulcers ___ Venereal Disease

Family Medical History

Father:

☐ Alive Current age __________

My father's general health is: ☐Excellent ☐ Good ☐ Fair ☐Poor Reason for poor health: _________________________________

☐ Deceased Age at death _____________Cause of death: __________________________

Mother:

☐ Alive Current age __________

My mother's general health is: ☐ Excellent ☐Good ☐Fair ☐Poor Reason for poor health:_________________________________

☐ Deceased ☐Age at death _____________Cause of death: _________________________

Siblings:

Number of brothers ______ Number of sisters ______ Age range

Health problems ______ ____

Familial Diseases

Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?

Check those to which the answer is yes (leave other blank).

____Heart attacks under age 50 ____Strokes under age 50 ____High blood pressure
____Elevated cholesterol ____Diabetes ____ Asthma or hay fever
____ Heart operations ____Glaucoma ____Obesity (20 or more pounds overweight)
____ Leukemia or cancer under age 60
____ Congenital heart disease (existing at birth but not hereditary)

List hospitalizations, including dates of and reasons for hospitalization

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List any drug allergies:

____
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