

Doctor's Family Clinic

Confidential Health History

Patient Name: _____ Date of Birth: _____ Age: _____

Date of Last Physical Exam (est.): _____ Chief Complaint Today: _____

Do you have a physician outside our facility? _____ If yes, what is their name? _____

Do you currently have or have had problems with the following symptoms in the past 12 months?

✓ Check all boxes that apply

<input type="checkbox"/> Appetite Changes	<input type="checkbox"/> Depression	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Back Trouble	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Sinus
<input type="checkbox"/> Balance/ Coordination	<input type="checkbox"/> Ears/Hearing	<input type="checkbox"/> Mole Changes	<input type="checkbox"/> Skin Infections
<input type="checkbox"/> Blackouts/Fainting	<input type="checkbox"/> Eyes/Vision	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Bleeding/Bruising	<input type="checkbox"/> Excessive Fatigue	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Sleep Changes
<input type="checkbox"/> Bowel Changes	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Nervousness/Anxiety	<input type="checkbox"/> Stomach/Indigestion
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Fever/Sweats/Chills	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Throat
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Urinary Problems
<input type="checkbox"/> Confusion	<input type="checkbox"/> Glands/Hormones	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Weight Gain/Loss
<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Headaches	<input type="checkbox"/> Sexual Difficulty	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Caffeine Use ↓	<input type="checkbox"/> Alcohol Use ↓	<input type="checkbox"/> Tobacco Use ↓	<input type="checkbox"/> Street Drug Use ↓
Frequency ____/Day	Frequency ____/Day	Frequency ____/Day	Frequency ____/Day

FEMALE ONLY

Abnormal Pap Smear

Bleeding Between Periods

Menstrual Pain

Painful Intercourse

MALE ONLY

Hot Flashes

Nipple Discharge

Vaginal Discharge

Erection Difficulties

Lump in Testicles

Penis Discharge

Prostate

Sore on Penis

Have you or a family member ever had any of the following?

Circle "S" for self or "F" for a Family Member (i.e. Mother, Father, Sibling, and Grandparent)

AIDS or HIV +	S F	Eye Disease	S F	Multiple Sclerosis	S F
Alcoholism	S F	Glaucoma	S F	Osteoporosis	S F
Arthritis	S F	Head Injury	S F	Pacemaker	S F
Asthma/Allergies	S F	Heart Disease	S F	Parkinson Disease	S F
Bladder Disease	S F	Hepatitis	S F	Psychiatric Care	S F
Blood Disorders	S F	High Blood Pressure	S F	Respiratory Problems	S F
Broken Bones	S F	High Cholesterol	S F	Rheumatic Fever	S F
Bulimia	S F	Kidney Problems	S F	STD	S F
Cancer	S F	Liver Disease	S F	Stomach Problems	S F
Chem. Dependency	S F	Low Blood Pressure	S F	Stroke	S F
Depression	S F	Migraine Headaches	S F	Suicide Attempt	S F
Diabetes	S F	Mononucleosis	S F	Thyroid Problems	S F
Emphysema	S F	Muscular Dystrophy	S F	Tuberculosis	S F
Epilepsy	S F				

Please List Current Medications: _____

Please List All Known Allergies: _____

Please List Major Surgeries/Hospitalizations: _____

To the best of my knowledge all the information above is correct.
I am aware it is my responsibility to update the provider of any changes.

Signature of Patient/Guardian _____ Relationship to Patient _____ Date _____

