PatientName-________________________Date__________DOB________

INITIAL HEALTH HISTORY

Do you have any active complaints presently? Please describe. Use separate page if needed.

1.____

2.____

3.____

4.____

5.____

Past Surgeries (operations)
Give approximate year

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Present Medications, Dose, and Times Taken

1. ____

2.____

3.____

4.____

5.____

6.____

7.____

8.____

9.____

Social History

Ever smoked? Most smoked on regularly basis/per day-

____

How many years smoked all-together?__________________When did you quit?_______________________

Alcohol-how many drinks (1 beer=1glass wine=1 oz. hard liquor) per day? Now____________________
How many when you drank the most? ________________How many years?______________
Street drugs– Presently________________________
Past_____________________________________
Domestic violence- Ever been a victim?__________ Describe __________________________________
Marital status-_________________________
Types of jobs & toxin exposure you have had ____

The last time you had any of the following (year): Explain any abnormalities on other side or lines at end of form.
Flu vaccine ______________ Tetanus shot _________________ Pneumonia shot __________________
Hepatitis vaccine __________ Tuberculosis test ________________ Stool blood test _______________
Rectal exam _____________Sigmoidoscopy/colonoscopy ________________Eye exam ______________
Dental exam ______________ Cholesterol test _______________ MEN- Prostate test ______________
WOMEN- Mammogram ____________ Pap smear ______________ Breast exam ________________
Bone Density test _______________ EXPLAIN ABNORMALITIES ON OTHER SIDE

Medication Allergies
____
____
____
____
____

FOR WOMEN ONLY
Date of last menses _________
Are menses regular _________
Spotting ______Pain________
Using birth control ________
What type?______________
# of pregnancies___________
# of live births ___________
# of miscarriages __________
# of abortions ____________

Have you or any family member had any of these problems in the past? Please check those that apply and explain on lines below

1.Head ,eyes, ears, nose or throat-such as headaches, cataracts, glaucoma, macular degeneration, stuffy/runny nose, allergies, sore throat, hoarse voice, cancers or lumps, trouble swallowing, heartburn.
Self present_______ Self past_______ Relative_______
2. Swollen glands-
Self present_______ Self past_______ Relative_______
3. Lungs, breathing-asthma, emphysema, cancer, sarcoid,

other lung diseases; shortness of breath, cough, wheezing.
Self present_______ Self past_______ Relative_______
4. Chest, breast-lumps; breast cancer, lumps, tenderness
Self present______ Self past_______ Relative_______
5. Heart or circulation-irregular heart beats; pressure or pain in chest, heart attack, high cholesterol, high blood pressure.
Self present_______ Self past_______ Relative_______
6. Abdomen/ digestion-Irritable bowel, colitis; ulcers; pain; bowel habit change; hemmoroids; constipation, diarrhea; black/bloody stool; cancers; liver/gall bladder; pancreas
Self present_______ Self past_______ Relative_______
7. Blood system-anemias; low platelets; leukemia; blood clots; other; blood transfusions
Self present_______ Self past_______ Relative_______
8.Muscles/bones-back pain; joint aches; arthritis (kind);gout,
Self present_______ Self past_______ Relative______
9. Urinary tract- urinating, prostate; frequent infections; incontinence; cancer;other
Self present_______ Self past_______ Relative_______
10. Genital-abn.Menses;endometriosis;cancer;other
Self present_______ Self past_______ Relative_______
11.Neurologic-strokes;seizures;passing out; walking; talking; tumors; trauma or other injury
Self present_______ Self past_______ Relative_______
12. Psychiatric-depression;bipolar;other
Self present_______ Self past_______ Relative_______
13. Skin-abnormalities;cancer;new mole
Self present_______ Self past_______ Relative_______
14. Endocrine-such as thyroid problems, diabetes, other
Self present_______ Self past_______ Relative_______
15. Other problems/symptoms-
Self present_______ Self past_______ Relative_______
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