Confidential Health History & Review of Systems

This is part of your permanent medical record. This information cannot be reproduced or shared without your permission

Name ____ Date of Birth ________________________ Height:_________

Present weight:___________ Have you recently gained or lost a significant amount of weight? {circle one} YES NO

If Yes, how much and over what time period? ____

Personal & Social History *Please check the appropriate column if any of the following apply to you*

Past	Present			
		Tobacco	Per day_______________	or per week__________________
		Alcohol	Per day_______________	or per week__________________
		Coffee/soda	Per day_______________	or per week__________________
		Drugs and related substances		
		Drug or alcohol dependence		

Past Health History

PREVIOUS INJURIES

Please list all major injuries, including car accidents and sporting injuries, even if you never received medical care:

Injury **Date Occurred** **Work Related? {yes or no}** **Does the Condition Recur? {yes or no}**

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PREVIOUS ADULT ILLNESSES

Please list all serious illness, such as ***ASTHMA, CANCER, DIABETES, HEART DISEASE, HEPATITIS, HIGH BLOOD PRESSURE, HIV INFECTION, SEIZURES, SICLE CELL ANEMIA, TUBERCULOSIS, or others:***

Date **Diagnosis** **Treatment Given** **Any remaining problems?**

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PAST SURGERIES & HOSPITALIZATIONS

Please list all major surgeries/operations and times you have been hospitalized even if you never had surgery:

Date **Type of surgery or cause of hospitalization** **Any complications?** **Any remaining problems?**

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MEDICINES

Please list all medicines you are taking, even if they are over-the-counter drugs, herbs, or vitamins:

Name **Why do you take it?** **What dosage?** **Taken for how long?**

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ALLERGIES

Please list all allergies, including medications, food and environmental substances:

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Family Health History *Please tell us about your birth parents and blood relatives*

Mother is {circle one} *Living* *Deceased* Age_________ Cause of death______________________

*Does your mother have any health problems?*____

Father is {circle one} *Living* *Deceased* Age_________ Cause of death______________________

*Does your father have any health problems?*____

Please check any of the following that apply to your blood relatives:

Alcoholism, or other chemical dependency	Cancer
Allergies	Diabetes Mellitus
Arthritis	Heart Disease
Anemia, blood, bleeding disorders	High Blood Pressure
Depression	Other:______________________________

Symptoms List *Please check the appropriate column for symptoms YOU have experienced before (PAST) or symptoms YOU are currently experiencing (PRESENT):*

PAST	PRESENT		PAST	PRESENT	
		General fatigue			Skin rash, dermatitis, eczema
		Headache			Chronic sinus problems
		Tinnitus, noises in the ear			Excessive thirst
		Fainting			Chronic cough
		Vision disturbances			Chest pain
		Dizziness, lightheadedness			Rapid heart beat
		Convulsions			Difficulty swallowing
		Muscular incoordination			Heartburn, indigestion
		TMJ (jaw) pain			Loss of appetite
		Neck pain			Abdominal pain
		Back pain			Nausea
		Swelling of joints			Painful urination
		Stiffness in joints			Frequent urination
		Shoulder pain			Loss of bowel or bladder control
		Arm pain			Constipation
		Elbow pain			Irregular bowel habits
		Wrist, hand pain			Irregular menstrual flow
		Hip pain			Excessive menstrual flow
		Leg pain			Breast tenderness, lumps
		Knee pain			Vaginal discharge
		Ankle, foot pain			PMS

Is there anything else you think Dr. Rasmussen should know?

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Patient signature____ **Date**__________________________