# HEALTH HISTORY

**Patient Name:** ____________________________ **Date of Birth:** ____________
**Today's Date:** ____________

This is a confidential record of your medical history and will be kept in the office.

**Chief Complaints**: (Please list why you are here or your present health concerns.)

______________________________________________________________________

______________________________________________________________________

**Past Medical History**: (Please circle or list your medical problems.)

___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

| Diabetes | No Yes | Tuberculosis | No Yes | Infectious Mono | No Yes |
|---|---|---|---|---|---|
| Hypertension | No Yes | Chicken pox | No Yes | Ankle swelling | No Yes |
| Sleep Apnea | No Yes | Bladder infection | No Yes | Mitral valve prolapse | No Yes |
| Asthma | No Yes | Gout | No Yes | Migraines | No Yes |
| Bronchitis | No Yes | High cholesterol | No Yes | AIDS or HIV | No Yes |
| Pneumonia | No Yes | Epilepsy | No Yes | Hepatitis | No Yes |
| Heart Disease | No Yes | Liver disease | No Yes | Kidney Disease | No Yes |
| Heart attack | No Yes | Thyroid disease | No Yes | Bleeding tendency | No Yes |
| Stroke | No Yes | Ulcer | No Yes | Rheumatic fever | No Yes |
| Blood clots | No Yes | Cancer | No Yes | Anemia | No Yes |
| Reflux | No Yes | Back pain | No Yes | Pancreatitis | No Yes |

**Past Surgical History**: (Please list any surgeries you have had.)

___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

___________________________ ___________________________

**Allergies**: (Please list your allergies and describe your reaction.)

___________________________ ___________________________

___________________________ ___________________________

**Social History**:

Do you drink alcohol? Yes No

Do you smoke? Yes No

If so, how many per day? ______

Do you use illegal drugs? Yes No

Marital status __________________

How many children? ____________

Occupation ____________________

Place of Birth __________________

**Family History**:

Are you parents still alive? Yes No (If not, please note cause of death.)

______________________________________________________________________

Any cancer or serious illness in the family? Please describe relative and disease.

______________________________________________________________________

# HEALTH HISTORY

| Medications | Dose | Time taken |
|---|---|---|
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**Do you have now or have you had within the last year? (Circle yes or no)**

| | | |
|---|---|---|
| Weakness or paralysis | No | Yes |
| Tire easily/weakness | No | Yes |
| Recent weight changes | No | Yes |
| Persistent fever | No | Yes |
| Night sweats | No | Yes |
| Skin rash | No | Yes |
| Skin trouble | No | Yes |
| Changes in hair/ nails | No | Yes |
| Headaches | No | Yes |
| Easy bleeding/bruising | No | Yes |
| Double vision | No | Yes |
| Blurred vision | No | Yes |
| Eye pain | No | Yes |
| Do you wear glass/contacts | No | Yes |
| Ringing in ears | No | Yes |
| Discharge from ears | No | Yes |
| Ear pain | No | Yes |
| Hearing loss | No | Yes |
| Frequent nose bleeds | No | Yes |
| Frequent colds | No | Yes |
| Sinus trouble | No | Yes |
| Loss of smell | No | Yes |
| Persistent hoarseness | No | Yes |
| Sore throat | No | Yes |
| Sore tongue/gums | No | Yes |
| Breast lump/discharge | No | Yes |
| Chronic or frequent cough | No | Yes |
| Shortness of breath | No | Yes |
| Bloody sputum | No | Yes |
| Wheezing | No | Yes |
| Chest pain/discomfort | No | Yes |
| Purple fingers/lips | No | Yes |
| Swelling hands/ feet/ankles | No | Yes |
| Leg cramps | No | Yes |
| Enlarged veins | No | Yes |
| Difficulty swallowing | No | Yes |

| | | |
|---|---|---|
| Heartburn | No | Yes |
| Abdominal cramping | No | Yes |
| Nausea/Vomiting | No | Yes |
| Vomited/coughed blood | No | Yes |
| Chronic diarrhea | No | Yes |
| Chronic constipation | No | Yes |
| Rectal bleeding | No | Yes |
| Black tarry stools | No | Yes |
| Dark urine | No | Yes |
| Yellow jaundice | No | Yes |
| Frequent urination | No | Yes |
| Painful urination | No | Yes |
| Leakage of urine | No | Yes |
| Difficulty starting stream | No | Yes |
| Blood in urine | No | Yes |
| Hemorrhoids | No | Yes |
| Backache | No | Yes |
| Joint pain/stiffness | No | Yes |
| Swollen joints | No | Yes |
| Muscle cramps/spasm | No | Yes |
| Sleeplessness | No | Yes |
| Seizures | No | Yes |
| Depression | No | Yes |
| Memory loss | No | Yes |
| Poor coordination | No | Yes |
| Dizziness/fainting spells | No | Yes |
| MEN ONLY | | |
| Discharge from penis | No | Yes |
| Pain/lump in testicle | No | Yes |
| Impotence | No | Yes |
| WOMEN ONLY | | |
| Do you menstruate? | No | Yes |
| Flow heavy? | No | Yes |
| Bleed between periods? | No | Yes |
| Pain with intercourse? | No | Yes |

# HEALTH HISTORY

**Weight Loss History**: (Only complete if you are here for weight loss surgery.)

My obesity started: (circle one) in childhood at puberty as an adult

after pregnancy after a traumatic event

My highest adult weight: ______________ When was this weight? ____________
My lowest adult weight: _______________ When was this weight? ____________
Most weight ever lost at one time: ______________ Program type: _________________

Have you ever taken the weight loss medicine Phen-Fen? Yes No
Have you ever taken any other medicine for weight loss? (Name) __________________

Do your best to remember your previous weight loss attempts.
Medically supervised weight loss attempts: (List type of program and dates.); Weight Loss Programs and/or Diets:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Exercise: Describe your exercise routine and any physical limitations.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Food Dislikes:

______________________________________________________________________

Food Likes or "downfalls":

______________________________________________________________________

Describe your typical daily food intake: Include time of day for each meal/snack

Breakfast:

Lunch:

Dinner:

Snacks: