Chart Number: _____ **Appointment is (Day/Time): _____**

PATIENT HEALTH HISTORY

Please complete all sections thoroughly upon registration, annually, and whenever any information herein changes. Mark "□ None" when appropriate.

SECTION 1: PATIENT IDENTIFICATION

Legal Name (Last, First, Middle Initial: _____ DOB: _____

REASON FOR VISIT (Please give specific symptoms**)**: _____
_____

SECTION 2: PATIENT'S MEDICAL HISTORY. Check all box(es) corresponding to current or past medical problem(s):

Constitutional
□ Fever
□ Chills
□ Headaches
□ Other: _____

Eyes
□ Blurred Vision
□ Double Vision
□ Pain
□ Other: _____

Neurological
□ Tremors
□ Dizzy Spells
□ Numbness
□ Other: _____

Endocrine
□ Excessive Thirst
□ Too Hot or Cold
□ Tired/Sluggish
□ Other: _____

Gastrointestinal
□ Abdominal Pain
□ Nausea/Vomiting
□ Heartburn
□ Other: _____

Cardiovascular
□ Chest Pain
□ Varicose Veins
□ High Blood Pressure
□ Other: _____

Integumentary
□ Skin Rash
□ Boils
□ Persistent Itch
□ Other: _____

Musculoskeletal
□ Joint Pain
□ Neck Pain
□ Back Pain
□ Other: _____

Ear/Nose/Throat/Mouth
□ Ear Infection
□ Sore Throat

□ Sinus Problems
□ Other: _____

Genitourinary
□ Urine Retention
□ Painful Urination
□ Frequency
□ Other: _____

Respiratory
□ Wheezing
□ Frequent Cough
□ Shortness of Breath
□ Other: _____

Hematologic
□ Swollen Glands
□ Blood Clotting Problem
□ Other: _____

Psychologic
□ Anxiety
□ Depressed
□ Satisfied with Life
□ Other: _____

Allergies. List all allergies and allergic reactions, or check: □ None.

Allergen	**Type of Reaction (Swelling, rash, nausea, vomiting, etc.)**
_____	_____
_____	_____
_____	_____
_____	_____

Other Medical Conditions Not Listed Above, or check: □ None.

_____

List All Surgeries, Including Dates of Each Surgery, or check: □ None.

_____
_____
_____

Family Medical History. List all illnesses in your immediate family and state relationship. Example: Mother, Father, Grandparents, Children; or check: □ None.

_____
_____
_____

SECTION 3: MEDICATIONS. List all prescriptions, over-the-counter medications, and supplements you take, including dose and frequency, or check: □ None.

Medications/Supplements	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do You?

Use Tobacco Products? (Example: Cigarettes, e-cigarettes, cigars, chew, nicotine gum, etc.)

□ No □ Formerly □ Yes

If yes, please specify:
- Start Date: _____
- If "Formerly" is checked: Stop Date: _____
- Amount(s) of each: _____
- Frequency(ies) of each: _____
- Amount(s) of each: _____

Drink? □ No □ Formerly □ Yes. How much? _____
If "Formerly" or "Yes" is marked, Frequency? _____

Use Drugs? □ No □ Formerly □ Yes. How what? _____
_____
How much? _____
If "Formerly" or "Yes" is marked, Frequency? _____

_____/_____ _____
Patient's or Legal Guardian's Name and Signature Date