

HEALTH SUMMARY

Patient name (please PRINT): _____ DOB: _____

ALLERGIES NONE: _____

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MEDICATIONS NONE: _____

What medications are you taking (including birth control pills, herbals, vitamins, dietary supplements, and over-the counter)?

PRESENT HEALTH CONDITIONS

YES	NO	DISEASE	YES	NO	DISEASE
		Irregular Heart Beat			Prostate Problems
		Congestive Heart Failure			Gout
		Heart Attack			Arthritis
		Heart Murmur			Skin Disease, Type:
		Rheumatic Fever			Stroke
		High Cholesterol			Epilepsy/Seizures
		High Blood Pressure			Diabetes/High Blood Sugar
		Asthma			Thyroid Problems – too high or too low
		Emphysema/Chronic Bronchitis			Anemia/Low Blood
		Blood Clot in Lung			Bleeding Problems, Type:
		Blood Clot in Leg			Blood Transfusion
		Tuberculosis			Cancer, Type:
		Gallstones			Anxiety
		Liver Disease, Type:			Depression
		Ulcers in Bowel/Stomach			Any Eye Conditions:
		Bleeding from Bowels			
		Kidney Disease, Type:			
		Kidney Stones			

SURGERIES

YES	NO	DISEASE	YES	NO	DISEASE
		Tonsils Removed			Back Disc Surgery
		Neck Artery Surgery			Hernia Surgery
		Open Heart Surgery/Catheterization			Other:
		Appendectomy			Eye Surgeries:
		Gallbladder Removal			
		Abdominal Surgery			
		Broken Bone Repair			
		Joint Scope Surgery			
		Joint Replacement of Knee / Hip			

REVIEW OF SYSTEMS

Do you current have any of the following problems:

If yes, please explain:

Chronic fever, unexpected weight loss/gain, fatigue.....	YES	NO _____
Eye/Ear/nose/throat problems (e.g. vision, hearing loss, sinus, sore throat).....	YES	NO _____
Respiratory problems (e.g. shortness of breath, wheezing, coughing).....	YES	NO _____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)...	YES	NO _____
Urinary problems (e.g. pain or discomfort, blood in urine).....	YES	NO _____
Skin problems (e.g. rashes, excessive dryness).....	YES	NO _____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints).....	YES	NO _____
Neurological problems (e.g. numbness, weakness, headaches, paralysis).....	YES	NO _____
Psychiatric problems (e.g. depression, anxiety).....	YES	NO _____

FAMILY HISTORY

YES	NO	DISEASE	RELATION TO YOU	YES	NO	DISEASE	RELATION TO YOU
		Heart Attack				Bleeding Problems	
		High Blood Pressure				Sickle Cell Anemia	
		High Cholesterol				Diabetes/High Blood Sugar	
		Asthma				Thyroid Problems	
		Tuberculosis				Cancer, Type:	
		Liver Disease				Alcohol Abuse	
		Kidney Disease				Anxiety or Depression	
		Gout / Arthritis				Eyes:	
		Osteoporosis					
		Stroke					
		Epilepsy / Seizures					

OTHER HISTORY

The following questions are very important and strictly confidential. Please answer them accurately.

Alcohol/Drugs:

Yes No Do you drink? How much? _____ How often? _____
 Yes No Do you use drugs? How much? _____ How often? _____ What kind? _____

What drugs have you used in the past? _____

Smoking:

Have you ever smoked: Yes No How many years did you smoke? _____ When did you quit? _____
 How many packs per day do you smoke now? _____ Do you use smokeless tobacco: Yes No

The above information is current and correct to the best of my knowledge.

I have reviewed the above history.

Patient/Guardian Signature

Date

Physician's Initial

Date