Today's Date: _______/_______/_______

HEALTH HISTORY

(Please Print)

Last Name	First	Middle	Birthdate	Age
			/ /	

Address (P.O. Box if necessary)	Home Phone No.
	( )

Email Address

Presently **active** health problems:

Previous surgery(s):

Previous hospitalization / major illnesses:

Medicines (all medicines frequently or recently used: including aspirin, vitamins, birth control pills & supplements)

Allergies or drug reactions (including topical products):

FAMILY HISTORY	Age if Living	Age at Death	Present Condition or Cause of Death	Check if any relatives have had:		Relationship
Father:				Diabetes	❑	
Mother:				Heart Trouble	❑	
Brothers:				Heart Attack	❑	
				High Blood Pressure	❑	
				Stroke	❑	
Sisters:				Cancer	❑	
				Ulcers	❑	
				Arthritis	❑	
Children:				Obesity (Overweight)	❑	
❑ Boy ❑ Girl				Mental Illness	❑	
❑ Boy ❑ Girl				Thyroid Trouble	❑	
❑ Boy ❑ Girl					❑	
					❑	

(see other side)

Check if you have had any of the following symptoms or findings to an unusual or significant degree.

HEAD

- ❑ Headache ________
- ❑ Fainting ________
- ❑ Dizziness ________
- ❑ Seizure ________
- ❑ Ear Trouble ________
- ❑ Sinus Trouble ________
- ❑ Stuffy Nose ________
- ❑ Nosebleeds ________
- ❑ Allergy ________
- ❑ Hoarseness ________
- ❑ Trouble Seeing ________
- ❑ Trouble Hearing ________

PULMONARY

- ❑ Cough ________
- ❑ Wheezing ________
- ❑ Pleurisy ________
- ❑ Pneumonia ________
- ❑ Tuberculosis ________
- ❑ Shortness of Breath ________
- ❑ Night Sweats ________
- ❑ Chest Pain ________
- ❑ Coughed up Blood ________
- ❑ Asthma ________

G.I.

- ❑ Trouble Swallowing ________
- ❑ Loss of Appetite ________
- ❑ Indigestion ________
- ❑ Heartburn ________
- ❑ Nervous Stomach ________
- ❑ Ulcers ________
- ❑ Vomiting Blood ________
- ❑ Passing Blood ________
- ❑ Dark (black) Stools ________
- ❑ Abdominal Pain ________
- ❑ Colitis ________
- ❑ Diarrhea ________
- ❑ Constipation ________
- ❑ Hemorrhoids ________
- ❑ Change in Bowel Habits ________
- ❑ Gallbladder Trouble ________
- ❑ Yellow Jaundice (Hepatitis) ________
- ❑ Liver Disease ________

HEART

- ❑ Heart Trouble ________
- ❑ Heart Murmer ________
- ❑ Rheumatic Fever ________
- ❑ Palpitation ________
- ❑ Irregular Heartbeat ________
- ❑ Easily Tired ________
- ❑ Angina ________
- ❑ Enlarged Heart ________
- ❑ High Blood Pressure ________
- ❑ Swollen Ankle ________

MUS. SKEL

- ❑ Arthritis ________
- ❑ Back Pain ________
- ❑ Bursitis ________
- ❑ Muscle Cramps ________
- ❑ Numbness ________
- ❑ Varicose Veins ________
- ❑ Phlibitis ________

LAB

- ❑ Abnormal Electro Cardiogram (EKG) ________
- ❑ Abnormal X-Ray ________
- ❑ High Blood Sugar ________
- ❑ Low Blood Sugar ________
- ❑ Anemia ________

ENDOCRINE

- ❑ Diabetes ________
- ❑ Hypoglycemia ________
- ❑ Thyroid Trouble ________
- ❑ Goiter ________
- ❑ Hot Flashes ________
- ❑ Fluid Retention ________
- ❑ Weakness ________
- ❑ Nervous ________
- ❑ Irritablity ________
- ❑ Depression ________
- ❑ Fatiue ________
- ❑ Trouble Sleeping ________

G/U

- ❑ Kidney Trouble ________
- ❑ Urine Infection ________
- ❑ Difficulty Urinating ________
- ❑ Prostate Trouble ________
- ❑ Sugar in Urine ________
- ❑ Blood in Urine ________
- ❑ Infertility ________
- ❑ Impotence ________
- ❑ Frigidity ________
- ❑ Other ________

Skin or Aesthetic Concerns

- ❑ Acne/Rosacea
- ❑ Brown Spots
- ❑ Broken Capillaries
- ❑ Enlarged Pores
- ❑ Textural Roughness/Changes
- ❑ Fine Lines/Wrinkles
- ❑ Volume Decline in Lips/Face

History of cosmetic treatments: ❑ No ❑ Yes Type: ________________

____

Sunscreen: ❑ No ❑ Yes SPF: ________________

Skin Regimen: ________________________

Ever Accutane: ❑ No ❑ Yes When: ________________

Females Only

Date last menstruated:________________ Period every ________ days.

Any menstrual problems: ❑ Heavy Periods ❑ Irregular Periods ❑ Infrequent Periods ❑ Painful Periods ❑ Spotting ❑ Discharge

Number of Pregnancies:____________ Date of Last Pap Smear: ____________ Abnormal Pap? ❑ No ❑ Yes

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For Complete Physical

Date of last complete physical:____________ Reason for present examination: ________________________

Notes:

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____

Form filled out by:________________________ Signature:________________________