

HEALTH HISTORY

CONFIDENTIAL

Please check current medical concerns below:

Currently, I have no concerns.

Constitutional

Weight loss
Weight gain

Eyes, Ears, Nose, Throat

Headaches
Blurry vision
Dental concerns

Breasts

Breast lump
Nipple discharge
Breast pain

Cardiovascular

Chest pain
Fainting
Shortness of breath with exercise

Gastrointestinal

Diarrhea
Constipation
Heartburn
Rectal bleeding/blood in stool

Skin

New rash

Genitourinary

Urinary urgency
Increase in urinary frequency
Pain with urination
Problems with bladder control
or urinary leakage
Abnormal vaginal discharge
Heavy periods
Irregular periods
Bleeding between periods
Pain with periods

Heme/Lymph

Frequent bruising
Cuts that do not stop bleeding
Personal or family history of blood clot

Musculoskeletal

Pain or swelling of muscles or joints

Neurological

Seizures
Numbness/weakness
in some part of the body

Respiratory

Shortness of breath
Wheezing
Cough

Psychiatric

Anxiety
Depression

SOCIAL HISTORY – HABITS

Personal Safety

	YES	NO
Has anyone close to you ever threatened to hurt you?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone ever hurt you physically?	<input type="checkbox"/>	<input type="checkbox"/>
Has anyone, including your partner, ever forced you to have sex?	<input type="checkbox"/>	<input type="checkbox"/>
Are you ever afraid of your partner?	<input type="checkbox"/>	<input type="checkbox"/>

Other

At what age did you first have intercourse? _____
How many sexual partners have you had? _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date