HEALTH HISTORY (All information is confidential)
Please check symptom you currently have or have in the past

General	**Respiratory**	**Cardiovascular**	**Skin**
__Chills __Body aches __Fatigue __Fever __Insomnia __Headaches __Dizziness __ Depression	__Chest congestion __Asthma/Wheezing __Cough __Shortness of breath __Tobacco use __Pneumonia __Bronchitis __Sinusitis	__Chest pain __High/Low blood pressure __Irregular heart beat __History of heart attack __welling of ankle/legs __Poor circulation	__Acne __Bruising __Eczema __Hives __itching __Rash __Tick bites
Gastroenterology	**Musculoskeletal** *Pain/Weakness/numbness/swelling*	**Ophthalmology**	**Allergies**
__Abdominal pain __Appetite change __Bloating __Black stool __Bowel change __Constipation __Diarrhea __Gas __Hemorrhoids __Vomiting __Nausea	__Arthritis __Back pain __Bone pain __Arms __Feet __Hips __Legs __Neck __Shoulder	__Blurry vision __Discharge __Double vision __Eye pain __Eye redness	__Itchy eyes __Rashes __Seasonal allergies __Sneezing
Men Only	**Women only**	**TEST/EXAM**	**VACCINE**
__Erection difficulties __Testicular pain or __swelling __Penile discharge __Other	__Abnormal pap smear __Bleeding between periods __Breast lump __Menstrual pain __Vaginal discharges Last pap smear : _____ Last mammogram: _____ Other	Colonoscopy_____ Rectal exam _____ TB test _____	__Tetanus/Td __Influenza __Pneumonia __Hepatitis
Conditions you've had in the past			
__Aids __Appendicts __Arthtitis __Asthma __Cancer __chicken pox __diabetes __epilepsy	__Heart disease,Hepatisis __high cholesterol __high blood pressure __herpes __HIV positive __Kidney diseases __Liver disease	__Migraines __Headaches __Depression __Memory loss __Pneumonia __Polio,Prostate problem __Rheumatic Fever	__Scarlet fever __Stroke __Thyroid problems __Tuberculosis, Ulcers __Veneral Disease __Weight loss/Gain
Family history	**Stroke**	**Social history**	
__Diabetes __Asthma __Heart disease	__High blood pressure __High cholesterol __Thyroid problems __Mental illness __Alcohol problems __Cancer __Others please specify	__Alcohol __Caffeine __Street drugs __tobacco Other	

Medications
List medications taken: _____
Pharmacy name: _____
Phone (___)_____
List of allergies to medications or substances _____

Signatures
To the best of my knowledge the above information furnished to this practice is complete and correct. I understand it is my responsibility to inform my doctor if any changes occur to myself, or any minor child.

_____ _____ _____
Signature of patient, parent, guardian | Print Name | Date