CONFIDENTIAL HEALTH HISTORY

Name_____ **Date**_____

In the box in front of each item, enter (x) if you currently have or had in the past the problem. Please leave the box blank if it does not apply. Past conditions are marked in the first box and Current conditions in the second.

GENERAL

Past	Current	
☐	☐	Fever
☐	☐	Chills
☐	☐	Night Sweats
☐	☐	Loss of sleep
☐	☐	Fatigue
☐	☐	Nervousness
☐	☐	Weight Loss/Gain
☐	☐	Allergies
☐	☐	Bleeding Problem
☐	☐	Anemia
☐	☐	Diabetes
☐	☐	Cancer
☐	☐	Thyroid
☐	☐	Disease/Goiter
☐	☐	Alcoholism
☐	☐	Drug Abuse
☐	☐	HIV positive
☐	☐	Other_____

EYE EAR NOSE THROAT

Past	Current	
☐	☐	Poor Vision
☐	☐	Pain in Eye(s)
☐	☐	Difficulty Hearing/Deaf
☐	☐	Nosebleeds
☐	☐	Nose Problems
☐	☐	Sinus Trouble
☐	☐	Dental Problems
☐	☐	Hoarseness
☐	☐	Tonsillectomy
☐	☐	Other_____

GASTROINTESTINAL

Past	Current	
☐	☐	Poor Appetite
☐	☐	Poor Digestion
☐	☐	Difficulty Swallowing
☐	☐	Belching or Gas
☐	☐	Frequent Nausea
☐	☐	Vomiting
☐	☐	Vomiting Blood
☐	☐	Pain over Abdomen
☐	☐	Ulcer
☐	☐	Black or Bloody Stools
☐	☐	Liver Problems
☐	☐	Gall Bladder Problems
☐	☐	Jaundice
☐	☐	Hernia
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Hemorrhoids
☐	☐	Appendicitis
☐	☐	Other_____

RESPIRATORY

Past	Current	
☐	☐	Difficult Breathing
☐	☐	Chronic Cough
☐	☐	Spitting Phlegm
☐	☐	Spitting Blood
☐	☐	Asthma/Wheezing
☐	☐	Pneumonia
☐	☐	Tuberculosis
☐	☐	Other_____

CARDIOVASCULAR

Past	Current	
☐	☐	Irregular Heartbeat
☐	☐	High blood pressure
☐	☐	Pain over Heart
☐	☐	Previous Heart Trouble
☐	☐	Ankle Swelling
☐	☐	Varicose Veins
☐	☐	Rheumatic Fever
☐	☐	Stroke
☐	☐	Other_____

GENITOURINARY

Past	Current	
☐	☐	Frequent Urination
☐	☐	Painful Urination
☐	☐	Blood in Urine
☐	☐	Kidney Disease
☐	☐	Urinary Infection
☐	☐	Inability to Control Urination
☐	☐	Breast Lump or Pain
☐	☐	Venereal Infection
☐	☐	Sexual Difficulties
☐	☐	Other_____

SKIN

Past	Current	
☐	☐	Itching
☐	☐	Bruising easily
☐	☐	Change in Mole(s)
☐	☐	Dryness/Wetness
☐	☐	Change in color
☐	☐	Skin Cancer
☐	☐	Other_____

WOMEN ONLY

Past	Current	
☐	☐	Live births
☐	☐	Miscarriage
☐	☐	Painful Periods
☐	☐	Excessive Flow
☐	☐	Irregular Cycles

WOMEN ONLY

Past	Current	
☐	☐	Vaginal Burning/Itching
☐	☐	Hot Flashes

MEN ONLY

Past	Current	
☐	☐	Testicular Swelling/Pain
☐	☐	Prostate problems
☐	☐	Other_____

NEUROLOGICAL

Past	Current	
☐	☐	Weakness
☐	☐	Twitching
☐	☐	Tremors
☐	☐	Headache
☐	☐	Fainting
☐	☐	Dizziness
☐	☐	Convulsions
☐	☐	Epilepsy
☐	☐	Numbness/Tingling
☐	☐	Arm/Leg Pain
☐	☐	Mental Disorder
☐	☐	Other_____

MUSCULOSKELETAL

Past	Current	
☐	☐	Swollen Joints
☐	☐	Spinal Curvature
☐	☐	Arthritis
☐	☐	Painful Joints
☐	☐	Muscle Aches/Soreness
☐	☐	Other_____

CHILDHOOD DISEASES

☐ Mumps
☐ Measles
☐ Chickenpox
☐ Other_____

SURGERIES

List dates and reasons

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

HOSPITALIZATIONS

List dates and reasons

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

HABITS/ADDICTIONS

☐ Smoking_____packs/day
☐ Alcohol
☐ Coffee
☐ Tea with caffeine
☐ Soft drinks
☐ Other_____

SLEEP

Hours per night_____

STRESS LEVELS

☐ High ☐ Medium
☐ Low ☐ None

EXERCISE

☐ None
☐ ____times per week
Type_____

ANY OTHER HEALTH CONCERNS?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

NOTES: