HEALTH HISTORY

Name ____Age_________Date____________

Reason for visit____

Primary Care Doctor:____________________Referring Doctor:______________________

Current medications (*include dosage and schedule):*

(1)___________________________ (10)__________________________
(2)___________________________ (11)__________________________
(3)___________________________ (12)__________________________
(4)___________________________ (13)__________________________
(5)___________________________ (14)__________________________
(6)___________________________ (15)___________________________
(7)___________________________ (16)___________________________
(8)___________________________ (17)___________________________
(9)___________________________ (18)___________________________

ALLERGIES (*what type of reaction*):___________________________
____
____
____

PAST MEDICAL AND SURGICAL HISTORY

Please list any medical conditions which you currently have or you have had in the past. Also list any surgeries including dates:

____
____
____
____
____
____
____
____
____
____

(OVER)

Please mark with X if any of the following apply:

( ) memory decline
( ) confusion
( ) reading problems
( ) fainting
( ) headaches
( ) depression
( ) anxiety
( ) insomnia
( ) fatigue
( ) weakness
( ) weight loss
( ) weight gain
( ) loss of appetite
( ) double vision
( ) blurred vision
( ) speech difficulty
( ) swallow difficulty
( ) hearing loss
( ) seizures
( ) falls
( ) imbalance
( ) shaking/tremors
( ) gait problems
( ) dyscoordination
( ) dizziness/vertigo
( ) arthritis
( ) muscle twitching
( ) muscle cramps
( ) numbness
( ) tingling
( ) neck pain
( ) arm pain
( ) back pain
( ) leg pain
( ) bladder incontinence
( ) constipation
( ) shortness of breath
( ) chest pain
( ) leg swelling
( ) other (*please list*)____
( ) other (*please list*)____

Occupation:_______________________**Education level**:_______________________
Marital status:____
Living arrangement *(Where and with whom do you live):*______________________________
Do you exercise? __________________What type and how often?_____________________
Do you drink alcohol?______________How much and how often?________________
Do you smoke?____________________How many packs per day?________________
Have you ever used drugs?__________When and what type?_____________________

Family History: *state relationship, medial condition, and, cause of death if applicable:*
____
____
____
____
____
____
____
____