

CONFIDENTIAL HEALTH HISTORY

Patient Name: \_\_\_\_\_

**SELF**

Please indicate with a check if YOU have had any of the following:

Date: \_\_\_\_\_

**GENERAL**

- 1) \_\_\_ night sweats
- 2) \_\_\_ fatigue
- 3) \_\_\_ excessive weight loss
- 4) \_\_\_ excessive weight gain
- 5) \_\_\_ allergies
- 6) \_\_\_ bleeding problems
- 7) \_\_\_ anemia
- 8) \_\_\_ diabetes
- 9) \_\_\_ cancer
- 10) \_\_\_ thyroid disease
- 11) \_\_\_ alcoholism
- 12) \_\_\_ drug abuse

**EENT**

- 13) \_\_\_ poor vision
- 14) \_\_\_ pain in eye
- 15) \_\_\_ difficulty hearing
- 16) \_\_\_ sinus problems
- 17) \_\_\_ trouble breathing
- 18) \_\_\_ halitosis
- 19) \_\_\_ hoarseness

**GI**

- 20) \_\_\_ poor appetite
- 21) \_\_\_ poor digestion
- 22) \_\_\_ difficulty swallowing
- 23) \_\_\_ belching or gas
- 24) \_\_\_ frequent nausea
- 25) \_\_\_ vomiting
- 26) \_\_\_ stomach pain
- 27) \_\_\_ ulcer
- 28) \_\_\_ black or bloody stool
- 29) \_\_\_ liver problems
- 30) \_\_\_ gall bladder problems
- 31) \_\_\_ diarrhea
- 32) \_\_\_ constipation
- 33) \_\_\_ appendicitis

**RESPIRATORY**

- 34) \_\_\_ difficulty breathing
- 35) \_\_\_ chronic cough
- 36) \_\_\_ spitting phlegm
- 37) \_\_\_ wheezing/asthma
- 38) \_\_\_ pneumonia
- 39) \_\_\_ tuberculosis

**CARDIOVASCULAR**

- 40) \_\_\_ irregular heartbeat
- 41) \_\_\_ high blood pressure
- 42) \_\_\_ pain over heart
- 43) \_\_\_ previous heart trouble
- 44) \_\_\_ ankle swelling
- 45) \_\_\_ rheumatic fever
- 46) \_\_\_ stroke

**GU**

- 47) \_\_\_ frequent urination
- 48) \_\_\_ painful urination
- 49) \_\_\_ blood in urine
- 50) \_\_\_ kidney disease
- 51) \_\_\_ urinary infection
- 52) \_\_\_ inability to control urination
- 53) \_\_\_ difficulty starting urine flow
- 54) \_\_\_ get up at night to urinate
- 55) \_\_\_ breast lump or pain
- 56) \_\_\_ sexually transmitted disease
- 57) \_\_\_ sexual difficulties

**MUSCULOSKELETAL**

- 58) \_\_\_ neck stiffness/pain
- 59) \_\_\_ pain between shoulders
- 60) \_\_\_ low back pain
- 61) \_\_\_ swollen joints
- 62) \_\_\_ painful joints
- 63) \_\_\_ muscle aches/soreness
- 64) \_\_\_ scoliosis
- 65) \_\_\_ arthritis

**NEUROLOGICAL**

- 58) \_\_\_ weakness
- 59) \_\_\_ tremors
- 60) \_\_\_ headaches
- 61) \_\_\_ fainting
- 62) \_\_\_ dizziness
- 63) \_\_\_ convulsions
- 64) \_\_\_ epilepsy
- 65) \_\_\_ numbness/tingling
- 66) \_\_\_ arm/leg pain

**SKIN**

- 67) \_\_\_ itching
- 68) \_\_\_ bruising easily
- 69) \_\_\_ change in mole
- 70) \_\_\_ skin cancer

**MALE ONLY**

- 71) \_\_\_ testicular swelling
- 72) \_\_\_ prostate problems

**FEMALE ONLY**

- 73) \_\_\_ painful periods
- 74) \_\_\_ excessive flow
- 75) \_\_\_ irregular cycles
- 76) \_\_\_ vaginal burning
- 77) \_\_\_ hot flashes
- 78) \_\_\_ yeast infections

**FAMILY**

Please indicate with a check if a sibling, parent, or grandparent has had any of the following. Do not include yourself.

- 79) \_\_\_ diabetes
- 80) \_\_\_ thyroid disease
- 81) \_\_\_ tuberculosis
- 82) \_\_\_ kidney disease
- 83) \_\_\_ high blood pressure
- 84) \_\_\_ heart disease
- 85) \_\_\_ cancer
- 86) \_\_\_ muscle, bone or nerve disease

List all prior major injuries and operations

List all medications/supplements/vitamins

<u>Name</u>	<u>Dose</u>	<u>Date Started</u>
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