PRIMARY CARE PHYSICIAN _____

HEALTH HISTORY
Confidential

#_____

Kush Patel, MD

Patient Name _____ Today's date _____

Age _____ Birthdate _____ Pharmacy Name _____

What is your reason for visit? _____

SYMPTOMS Check (√) symptoms you currently have or have had in the past year.

GENERAL
- □ Chills
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fever
- □ Forgetfulness
- □ Headache
- □ Loss of sleep
- □ Loss of weight
- □ Nervousness
- □ Numbness
- □ Sweats

SKIN
- □ Bruise easily
- □ Hives
- □ Itching
- □ Change in moles
- □ Rash
- □ Scars
- □ Sore that won't heal

GENITO-URINARY
- □ Blood in urine
- □ Frequent urination
- □ Lack of bladder control
- □ Painful urination

GASTROINTESTINAL
- □ Appetite poor
- □ Bloating
- □ Bowel changes
- □ Constipation
- □ Diarrhea
- □ Excessive hunger
- □ Excessive thirst
- □ Gas
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Rectal Bleeding
- □ Stomach pain
- □ Vomiting
- □ Vomiting blood

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- □ Arms
- □ Back
- □ Feet
- □ Hands
- □ Hips
- □ Legs
- □ Neck
- □ Shoulders

WOMEN only
- □ Abnormal Pap Smear
- □ Bleeding between periods
- □ Breast lump
- □ Extreme menstrual pain
- □ Hot flashes
- □ Nipple discharge
- □ Painful intercourse
- □ Vaginal discharge
- □ Other

Date of last menstrual period ____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? ___

Number of children __

MEN only
- □ Breast lump
- □ Erection difficulties
- □ Lump in testicles
- □ Penis discharge
- □ Sore on penis
- □ Other

EYE, EAR, NOSE, THROAT
- □ Bleeding gums
- □ Blurred vision
- □ Crossed eyes
- □ Difficulty swallowing
- □ Double vision
- □ Earache
- □ Ear discharge
- □ Hay fever
- □ Hoarseness
- □ Loss of hearing
- □ Nosebleeds
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems
- □ Vision - Flashes
- □ Vision - Halos

CARDIOVASCULAR
- □ Chest pain
- □ High blood pressure
- □ Irregular heart beat
- □ Low blood pressure
- □ Poor circulation
- □ Rapid heart beat
- □ Swelling of ankles
- □ Varicose veins

CONDITIONS Check (√) conditions you have or have had in the past.

- □ AIDS
- □ Alcoholism
- □ Anemia
- □ Anorexia
- □ Appendicitis
- □ Arthritis
- □ Asthma
- □ Bleeding Disorders
- □ Breast Lump
- □ Bronchitis
- □ Bulimia
- □ Cancer
- □ Cataracts
- □ Chemical Dependency
- □ Chicken Pox
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Glaucoma
- □ Goiter
- □ Gonorrhea
- □ Gout
- □ Heart Disease
- □ Hepatitis
- □ Hernia
- □ Herpes
- □ High Cholesterol
- □ HIV Positive
- □ Kidney Disease
- □ Liver Disease
- □ Measles
- □ Migraine Headaches
- □ Miscarriage
- □ Mononucleosis
- □ Multiple Sclerosis
- □ Mumps
- □ Pacemaker
- □ Pneumonia
- □ Polio
- □ Prostate Problem
- □ Psychiatric Care
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Stroke
- □ Suicide Attempt
- □ Thyroid Problems
- □ Tonsillitis
- □ Tuberculosis
- □ Typhoid Fever
- □ Ulcers
- □ Vaginal Infections
- □ Venereal Disease

MEDICATIONS List medications you are currently taking.	ALLERGIES To medications or substances

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (√) if, your blood relatives had any of the following:

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

SURGERY HISTORY		
YEAR	HOSPITAL	TYPE OF SURGERY PERFORMED

Have you ever had a blood transfusion? □ Yes □ No If yes, please give approximate dates. _____

HEALTH HABITS Check (√) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Alcohol	
	Other	

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