



HEALTH HISTORY

Name: _____ Gender: M F Date of Birth: _____

Date of last physical examination: _____ Reason for this visit: _____

Pharmacy: _____ Telephone: (____) ____ - _____

SYMPTOMS

<p style="text-align: center;">General</p> <p>Chills Depression Dizziness Fainting Fever Forgetfulness Headache Loss of Sleep Loss of Weight Nervousness Numbness Sweats</p> <p style="text-align: center;">Muscle/Joint/Bone Pain, Weakness, Numbness:</p> <p>Arms Back Legs Feet Neck Hands Shoulders</p> <p style="text-align: center;">Genito-Urinary</p> <p>Blood in Urine Frequent Urination Lack of Bladder Control Painful Urination</p>	<p style="text-align: center;">Gastrointestinal</p> <p>Appetite Poor Bloating Bowel Changes Constipation Diarrhea Excessive Hunger Excessive thirst Gas Hemorrhoids Indigestion Nausea Rectal Bleeding Stomach Pain Vomiting Vomiting Blood</p> <p style="text-align: center;">Cardiovascular</p> <p>Chest Pain High Blood Pressure Irregular Heart Beat Low Blood Pressure Poor Circulation Rapid Heart Beat Swelling of Ankles Varicose Veins</p>	<p style="text-align: center;">Eye, Ear, Nose, Throat</p> <p>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</p> <p style="text-align: center;">Skin</p> <p>Bruise Easily Hives Itching Change in Moles Rash Scars Sore that won't heal</p>	<p style="text-align: center;">MEN only</p> <p>Breast Lump Erection Difficulties Lump in Testicles Penis Discharge Sore on Penis Other</p> <p style="text-align: center;">WOMEN only</p> <p>Abnormal Pap Smear Bleeding Between Periods Breast Lump Extreme Menstrual Pain Hot Flashes Nipple Discharge Painful Intercourse Vaginal Discharge Other LMP Date _____ Date of last Pap Smear _____ Have You Had A Mammogram? Are You Pregnant? Number of Children _____</p>
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CONDITIONS

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

