

# Confidential Health History

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date of Last Physical Examination \_\_\_\_\_

What is your reason for today's visit? \_\_\_\_\_

## Symptoms Check symptoms you currently have or have in the past year.

### General

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

### Cardiovascular

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

### Gastrointestinal

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

### Genito-Urinary

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

### Muscle/Joint/Bone

Pain, weakness, numbness in:

- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders

### Skin

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

### Women Only

- Have you ever had any menstrual abnormalities?
- \_\_\_\_\_
- Are you pregnant?

### 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

## Conditions Check conditions you have or have had in the past

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

## Health and Occupation

### Check which substances you use and how much:

- Caffeine \_\_\_\_\_
- Tobacco \_\_\_\_\_
- Alcohol \_\_\_\_\_
- Other \_\_\_\_\_

### Check if your work exposes you to the following:

- Stress
- Hazardous Substances
- Heavy Lifting
- Other \_\_\_\_\_

Your occupation \_\_\_\_\_

### Questions?

# Confidential Health History

**Medications** List medications you are currently taking

**Allergies** To medications


Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

**Family History** Fill in health information about your family

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following:	
					Disease	Relationship to you
Father					<input type="checkbox"/> Asthma, Hay Fever	
Mother					<input type="checkbox"/> Other Allergies	
Brothers					<input type="checkbox"/> Arthritis, Gout	
					<input type="checkbox"/> Cancer	
					<input type="checkbox"/> Diabetes	
					<input type="checkbox"/> Heart Disease, Strokes	
Sisters					<input type="checkbox"/> High Blood Pressure	
					<input type="checkbox"/> Kidney Disease	
					<input type="checkbox"/> Tuberculosis	
					<input type="checkbox"/> Other	

List family members that have been seen by Denver Allergy and Asthma \_\_\_\_\_

**Hospitalization, Serious Illness and Injuries**

Date	Hospital	Reason for Hospitalization	Outcome

Date	Serious Illness/Injury	Outcome

Have you ever had a blood transfusion? Yes / No If yes, please give appropriate dates \_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed By \_\_\_\_\_ Date \_\_\_\_\_