



HEALTH HISTORY (Confidential)

Name: _____ Today's Date: _____

Age: _____ Birthdate: _____ Date of last Physical Exam: _____

SYMPTOMS Check symptoms you currently have or have had in the past year

Grid of symptom categories: GENERAL, GASTROINTESTINAL, EYE, EAR, NOSE, THROAT, MEN ONLY, WOMEN ONLY, MUSCLE/JOINT/BONE, GENITO-URINARY, and SKIN.

CONDITIONS: Check conditions you have or have had in the past.

Grid of condition categories: AIDS, Alcoholism, Anemia, Anorexia, Appendicitis, Arthritis, Asthma, Bleeding Disorder, 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, Prostrate Problem, Psychiatric Care, Rheumatic Fever, Scarlet Fever, Stroke, Suicide Attempt, Thyroid Problems, Tonsillitis, Tuberculosis, Typhoid Fever, Ulcers, Vaginal Infections, Venereal Diseases.

ALLERGIES: TO MEDICATIONS OR SUBSTANCE WITH REACTIONS:

Blank lines for entering allergy information.

