



## HEALTH HISTORY

**CHECK** those conditions that you have had in the past.

**CIRCLE** those conditions that you currently experience.

Indicate the **AGE** of onset of these conditions.

### SYMPTOMS

#### General

Chills  
Dizziness  
Easily bruise  
Fainting  
Fatigue  
Fever  
Forgetfulness  
Lightheadedness  
Loss of energy  
Loss of sleep  
Motion sickness  
Nervousness  
Night sweats  
Sweating  
Unsteadiness  
Weight loss  
Weight gain

#### Eye

Blurred vision  
Crossed-lazy eye(s)  
Double vision  
Eye pain  
Farsightedness-can see far  
away easily  
Loss of vision  
Nearsightedness-close easily  
Visual flashes  
Visual halos  
Had laser surgery  
Wear glasses-contacts

#### Ear, Nose, Throat

Allergies-hay fever  
Bleeding gums  
Decrease hearing  
Earache  
Ear discharge  
Ear fullness  
Ear infections  
Ear ringing-buzzing  
Hoarseness  
Jaw clicking  
Jaw locking  
Nosebleeds  
Post-nasal drip  
Sinus problems  
Sore throat  
Swallowing difficulty

#### Cardiovascular

Chest Pain  
Chest pressure

Heart murmur  
High blood pressure  
Irregular heart beat  
Leg pain when walk  
Low blood pressure  
Palpitations  
Phlebitis  
Poor circulation  
Shortness of breath  
on exertion  
lying flat  
Swollen ankles  
Varicose veins

#### Pulmonary

Cough  
with sputum  
green white  
yellow clear  
bloody  
Wheezing

#### Gastrointestinal

Abdominal pain  
Black stools  
Bloating  
Blood in stools  
Constipation  
Diarrhea  
Difficulty swallowing  
Heartburn  
Hemorrhoids  
Mucous in stools  
Nausea  
Vomiting

#### Neurology

Cold or numb extremities  
Convulsions  
Headaches  
Memory loss  
Moodiness  
Muscle weakness  
Numbness-tingling  
Tremors  
Phobias  
Vertigo/Spinning

#### Dermatology

Change in moles  
Eczema  
Hives  
Itching  
Psoriasis  
Rashes

Scars  
Sores that won't heal  
Yellow skin or eyes

#### Genitourinary

Bladder control  
Blood in urine  
Decrease force of urinary  
Painful intercourse  
Painful urination  
Pelvic pain  
Sexual dysfunction  
Urinary hesitancy

#### Musculoskeletal

Joint stiffness  
Joint swelling  
Pain in:  
neck jaw  
shoulder arms  
hands back  
hips legs  
feet \_\_\_\_\_

#### Female only

Number of pregnancies \_\_\_\_\_  
Number of live births \_\_\_\_\_  
Number of miscarriages \_\_\_\_\_  
Age of onset of menses \_\_\_\_\_  
Date of last period \_\_\_\_\_  
Method of birth control \_\_\_\_\_  
Periods are:  
regular irregular  
painful  
heavy scant  
Duration:  
Days in between \_\_\_\_\_  
Days of flow \_\_\_\_\_  
Pregnancies:  
Total \_\_\_\_\_  
Term \_\_\_\_\_  
Premature \_\_\_\_\_  
Abortions \_\_\_\_\_  
Living \_\_\_\_\_