Name____________________

Health History

Relatives include blood relations such as mother, father, brother, sister, son, daughter, grandparent, aunt &/or uncle

| | You/Relatives | | | You/Relatives | | | You/Relatives | |
|---|---|---|---|---|---|---|---|---|
| COPD/emphysema | 0 | 0 | Hay Fever/Allergies | 0 | 0 | Alcoholism | 0 | 0 |
| Heart Disease | 0 | 0 | High Blood Pressure | 0 | 0 | Liver Disease | 0 | 0 |
| Asthma | 0 | 0 | Tuberculosis | 0 | 0 | Drug Abuse History | 0 | 0 |
| Rheumatic Fever | 0 | 0 | Seizures | 0 | 0 | Osteoporosis | 0 | 0 |
| Heart Murmur | 0 | 0 | Leukemia | 0 | 0 | Arthritis | 0 | 0 |
| Heart Attack | 0 | 0 | AIDS or HIV | 0 | 0 | Depression | 0 | 0 |
| Stroke | 0 | 0 | Hepatitis/ Jaundice | 0 | 0 | Psychiatric problem | 0 | 0 |
| Cardiac Pacemaker | 0 | 0 | STD | 0 | 0 | Kidney Disease | 0 | 0 |
| Angina | 0 | 0 | Thyroid Problem | 0 | 0 | Indigestion or Ulcers | 0 | 0 |
| Anemia | 0 | 0 | Radiation Therapy | 0 | 0 | High cholesterol | 0 | 0 |
| Low Blood Pressure | 0 | 0 | Glaucoma | 0 | 0 | Autoimmune disease | 0 | 0 |
| Diabetes | 0 | 0 | Joint Replacement | 0 | 0 | | | |
| Cancer | 0 | 0 | Any other disease | | | Details__________________ | | |
| Type of cancer_______________ | | | or condition | 0 | 0 | __________________________ | | |

Continue on back if needed

Surgeries/Hospitalizations and dates____________________________________________

____________________________________________________________________________

Current Medications and Dosages________________________________________________

____________________________________________________________________________

____________________________________________________________________________

Current Vitamins, Herbs and Supplements_________________________________________

____________________________________________________________________________

Allergies to Medications, Foods or other Substances_______________________________

Have you ever used tobacco?________ Current type and amount of use___________________________

Women: Are you pregnant?________ Are you on oral or other contraceptives?______________________

Comments___________________________________________________________________

____________________________________________________________________________

Please indicate any symptoms you have in the past week, 6 months and 5 years

| | Week | 6 mos | 5 yrs | | Week | 6 mos | 5 yrs |
|---|---|---|---|---|---|---|---|
| Weight loss | 0 | 0 | 0 | | | | |
| Weight gain | 0 | 0 | 0 | Abdominal pain | 0 | 0 | 0 |
| Fever | 0 | 0 | 0 | Nausea/vomiting | 0 | 0 | 0 |
| Fatigue | 0 | 0 | 0 | Diarrhea | 0 | 0 | 0 |
| Weakness | 0 | 0 | 0 | Constipation | 0 | 0 | 0 |
| Chills/Sweats | 0 | 0 | 0 | Blood in stool | 0 | 0 | 0 |
| Excessive thirst | 0 | 0 | 0 | Breast lump/discharge | 0 | 0 | 0 |
| Excessive urination | 0 | 0 | 0 | Palpitations | 0 | 0 | 0 |
| Changes in vision | 0 | 0 | 0 | Leg pain with exercise | 0 | 0 | 0 |
| Difficulty hearing | 0 | 0 | 0 | Swollen ankles | 0 | 0 | 0 |
| Ringing in ears | 0 | 0 | 0 | Fainting | 0 | 0 | 0 |
| Teeth/gums problems | 0 | 0 | 0 | Night-time urination | 0 | 0 | 0 |
| Hay fever/allergies | 0 | 0 | 0 | Leaking urine | 0 | 0 | 0 |
| Coughing/wheezing | 0 | 0 | 0 | Easy bruising/bleeding | 0 | 0 | 0 |
| Difficulty breathing | 0 | 0 | 0 | Rash or mole change | 0 | 0 | 0 |
| Chest pain/discomfort | 0 | 0 | 0 | Muscle/joint pain | 0 | 0 | 0 |
| Easily winded | 0 | 0 | 0 | Unexplained lumps | 0 | 0 | 0 |
| Headaches | 0 | 0 | 0 | Problems with sleep | 0 | 0 | 0 |
| Dizziness/lightheaded | 0 | 0 | 0 | Depression/sadness | 0 | 0 | 0 |
| Numbness | 0 | 0 | 0 | Sexual concern | 0 | 0 | 0 |
| Memory Loss | 0 | 0 | 0 | Penile discharge | 0 | 0 | 0 |
| Loss of coordination | 0 | 0 | 0 | Vaginal discharge | 0 | 0 | 0 |
| Anxiety /Stress | 0 | 0 | 0 | Unusual vaginal bleeding | 0 | 0 | 0 |
| Other | 0 | 0 | 0 | Hot flashes | 0 | 0 | 0 |

If other please explain________________________________________________________________