HEALTH HISTORY

Chief Complaint: History of present illness: Location:	ck trouble no yes gh Blood Pressure no yes W Blood Pressure no yes W Blood Pressure no yes w Blood Pressure no yes chrorrhoids no yes tral Valve Prolapse no yes tral Valve Prolapse no yes tral Valve Prolapse no yes Hepatitis no yes Clicer no yes Kidney Disease no yes Kidney Disease no yes Bleeding Tendency no yes (please list): yes (please list):
History of present illness: Location: (Where is the pain/problem?) Severity (How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?) Timing (Does the pain/problem occur at a specific time?) Associated signs/symptoms (What other associated problems have you been having? Past Medical History Have you ever had the following: (Circle "no" or "yes", leave blank if uncert Measles no yes Bladder Infections no yes High Chickenpox no yes Epilepsy no yes Low Whooping Cough no yes Migraine Headaches no yes He Scarlet Fever no yes Tuberculosis no yes Da Diphtheria no yes Diabetes no yes Ass Smallpox no yes Cancer no yes Higher Disease no yes Hernia no yes Brathritis no yes Blood or Plasma Mil Venereal Disease no yes Transfusions no yes Str	(Example: normal versus abnormal color, activity, etc.) Duration (How long have you had this pain/problem?, or, When did it start?) Context (Where were you at the onset of this pain/problem?) Modifying factors (What makes the pain/problem worse or better?, or, Have you had previous episodes?) ain) ck trouble no yes gh Blood Pressure no yes W Blood Pressure no yes Bleeding Tendency no yes W Blood Pressure no yes W Blood Pressure no yes Bleeding Tendency no yes W Blood Pressure no yes W Blood Pressure no yes Bleeding Tendency no yes W Blood Pressure no yes W Blood Pressu
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Rheumatic Fever no yes Glaucoma no yes Inf Heart Disease no yes Hernia no yes Br Arthritis no yes Blood or Plasma Mi Venereal Disease no yes Transfusions no yes Str	ectious Mono no yes onchitis no yes tral Valve Prolapse no yes
Heart Disease no yes Hernia no yes Brod or Plasma Mi Arthritis no yes Blood or Plasma Mi Venereal Disease no yes Transfusions no yes Str	onchitis no yes tral Valve Prolapse . no yes
Arthritis	tral Valve Prolapse no yes
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Provious Hospitalizations/Surgarias/Sarious Illnesses	oke no yes
Previous Hospitalizations/Surgeries/Serious Illnesses	When? Hospital, City, State
Medications: (Include nonprescription)	
Patient social history:	
Marital status Single: Married: Separate Use of alcohol: Never: Rarely: Moderat	ed: Divorced: Widowed: be: Daily:
Use of tobacco: Never: Previously, but quit:	Current packs / day:
Use of drugs: Never: Type/Frequency:	
Excessive exposure	Air-borne
at home or work to: Fumes: Dust: Solvents:	: Particles: Noise:
Family medical history:	VD 10 VE 1
Age Diseases Father	If Deceased, Cause of Death
Mother	
Siblings	
Sanua	
Spouse Children	

☐ Constitutional Symptoms		☐ Genitourinary		☐ Psychiatric
Good general health lately No	Yes	Frequent urination No Y	es	Memory loss or confusion No Ye
Recent weight change No	Yes	Burning or painful urination No Ye	es	Nervousness
FeverNo	Yes		es	Depression
Fatigue	Yes	Change in force of strain		Insomnia No Ye
Headaches No	Yes	when urinating No Ye	es	
☐ Eyes		Incontinence or dribbling No Ye		☐ Endocrine
Eye disease or injury No	Yes	Kidney stones No Yo	es	Glandular or hormone problem . No Ye
Wear glasses/contact lenses No	Yes	Sexual difficulty No Y		Excessive thirst or urination No Ye
Blurred or double vision No	Yes	Male - testicle pain No Ye		Heat or cold intolerance No Ye
		Female - pain with periods No You		Skin becoming dryer No Ye
☐ Ears/Nose/Mouth/Throat		Female - irregular periods No Yo		Change in hat or glove size No Ye
Hearing loss or ringing No	Yes	Female - vaginal discharge No Yo	es	
Earaches or drainage No	Yes	Female - # of pregnancies	_ '	☐ Hematologic/Lymphatic
Chronic sinus problem or rhinitis . No Nose bleeds No	Yes Yes	Female - # of miscarriages		Slow to heal after cuts No Ye
Mouth soresNo	Yes	Female - date of last pap smear	_	Bleeding or bruising tendency . No Ye
Bleeding gums No	Yes	☐ Musculoskeletal		Anemia
Bad breath or bad taste No	Yes	Joint pain No Ye	se.	Phlebitis
Sore throat or voice change No	Yes	Joint stiffness or swelling No Yo		Enlarged glands No Ye
Swollen glands in neck No	Yes	Weakness of muscles or joints. No Ye		Emarged glands
		Muscle pain or cramps No Ye		Allergic/Immunologic
☐ Cardiovascular	.,	Back pain No Ye		History of skin reaction or other adverse
Heart troubleNo	Yes	Cold extremities No Ye		reaction to:
Chest pain or angina pectoris No Palpitation No	Yes Yes	Difficulty in walking No Ye		Penicillin or other antibiotics No Ye
Shortness of breath w/walking	res			Morphine, Demerol,
or lying flat	Yes	☐ Integumentary (skin, breast)		or other narcotics No Ye
Swelling of feet, ankles or hands. No	Yes	Rash or itching No Ye	es	Novocain or other anesthetics . No Ye
•		Change in skin color No Ye	es	Aspirin or other pain remedies No Ye
☐ Respiratory		Change in hair or nails No Ye	es	Tetanus antitoxin
Chronic or frequent coughs No	Yes	Varicose veins No Ye	es	or other serums
Spitting up blood No	Yes	Breast pain No Ye	es	lodine, Merthiolate or
Shortness of breath No	Yes	Breast lump No Ye		other antiseptic No Ye
Wheezing No	Yes	Breast discharge No Ye	es	Other drugs/medications:
☐ Gastrointestinal		□ Na		
Loss of appetite No	Yes	□ Neurological		Vnouga food alloraine
Change in bowel movements No	Yes	Frequent or recurring headaches No Ye		Known food allergies:
Nausea or vomiting No	Yes	Light headed or dizzy No Ye Convulsions or seizures No Ye		
Freguent diarrhea No	Yes	Numbness or tingling sensations No Ye		Environmental allergies:
Painful bowel movements		Tremors No Ye		
or constipationNo	Yes	Paralysis No Ye		
Rectal bleeding or blood in stool No Abdominal pain No	Yes Yes	Head injury No Ye		
Abdominar pairr	162	17000 11/01/17 17 17 17 17 17 17 17 17 17 17 17 17 1	,,,	
also authorize the healthcare staff to	health	ns on this form have been accurately an . It is my responsibilty to inform the docto n the necessary services I may need.	swere r's off	ed. I understand that providing incorrectice of any changes in my medical status.
Signature of Parent or Guardian				Date
Doctor's Review				
Doctor 3 Neview				
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Signature of Doctor			I	Date: