Health History

Name_____Date_____

Age_____DOB_____Last Physical Exam_____

Reason for your visit today_____

MEDICAL GROUP
spring of youth
VEIN & LASER CENTER * AESTHETICS CENTER
"Excellence with a human touch"

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

	General		Gastrointestinal		Eye, Ear, Nose, Throat		Men only
	Chills		Poor appetite		Bleeding gums		Breast lump
	Depression		Bloating		Blurred vision		Erection Difficulties
	Dizziness		Bowel changes		Crossed eyes		Lump in testicles
	Fainting		Constipation		Difficulty swallowing		Penis discharge
	Fever		Diarrhea		Double vision		Sore on penis
	Forgetfulness		Excessive hunger		Earache		Other
	Headache		Excessive thirst		Hay fever		**Women Only**
	Loss of sleep		Gas		Hoarseness		Abnormal pap smear
	Loss of weight		Hemorrhoids		Loss of hearing		Bleeding between periods
	Nervousness		Indigestion		Nosebleeds		Breast lump
	Numbness		Nausea		Persistent cough		Extreme menstrual pain
	Sweats		Rectal bleeding		Ringing in ears		Hot flashes
	Muscle/Joint/Bone Pain, weakness, numbness in:		Stomach Pain		Sinus problems		Nipple discharge
	Arms		Vomiting		Vision-Flashes		Painful intercourse
	Back		Vomiting blood		Vision-Halos		Vaginal discharge
	Feet		**Cardiovascular**		**Skin**		Other
	Hands		Chest pain		Bruise easily		**Dates of:**
	Hips		High Blood Pressure		Hives		Last menstrual cycle:
	Legs		Irregular heart beat		Itching		
	Neck		Low Blood Pressure		Change in moles		Last pap smear:
	Shoulders		Poor Circulation		Rash		
	Genito-Urinary		Rapid Heart Beat		Scars		Mammogram:
	Blood in urine		Swelling of ankles		Sore that won't heal		
	Frequent urination		Varicose veins				Are you pregnant?:
	Lack of bladder control						
	Painful urination						# of children:

CONDITIONS check conditions you have or have had in the past.

	AIDS		Chemical dependency		High Cholesterol		Prostate Problem
	Alcoholism		Chicken Pox		HIV Positive		Psychiatric Care
	Anemia		Diabetes		Kidney Disease		Rheumatic Fever
	Anorexia		Emphysema		Liver Disease		Scarlet Fever
	Appendicitis		Epilepsy		Measles		Stroke
	Arthritis		Glaucoma		Migraine Headaches		Suicide Attempt
	Asthma		Goiter		Miscarriage		Thyroid Problems
	Bleeding disorders		Gonorrhea		Mononucleosis		Tonsillitis
	Breast lump		Gout		Multiple Sclerosis		Tuberculosis
	Bronchitis		Heart Disease		Mumps		Typhoid Fever
	Bulimia		Hepatitis		Pacemaker		Ulcers
	Cancer		Hernia		Pneumonia		Vaginal Infections
	Cataracts		Herpes		Polio		Venereal Disease

MEDICATIONS list medications you are currently taking	**ALLERGIES**
Pharmacy: Phone:	

FAMILY HISTORY fill in health information about your immediate family							
Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following:		
Father						**Disease**	**Relationship to you**
Mother						Arthritis, Gout	
Brothers						Asthma, Hay Fever	
						Cancer	
						Chemical Dependency	
						Diabetes	
Sisters						Heart Disease, Strokes	
						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Hospitalizations			**Pregnancy History**		
YEAR	Hospital	Reason	Year of birth	Sex at Birth	Complications if any

Serious Illness/Injuries	**Date**	**Outcome**	**Health Habits** check which substances you use and describe how much you use.		
				Caffeine	
				Tobacco	
				Street Drugs	
				Other	
			Occupational Concerns check if your work exposes you to the following.		
				Stress	
				Hazardous Substances	
				Heavy Lifting	
				Other	
Have you ever had a blood transfusion? Yes No If yes, please give approximate dates._____			Your Occupation:		

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

_____ _____

Reviewed by Date