Patient Health History

Room # _____

Patient # _____

Patient Name _____ Age_____ Date of Birth _____

Reason for visit _____ How long? _____ **Pharmacy** _____

MARK SYMPTOMS YOU *CURRENTLY* HAVE AND *HOW LONG*_____(DAYS/WEEKS)

Constitutional
- ❑ Chills
- ❑ Decreased appetite
- ❑ Fatigue
- ❑ Fever
- ❑ Sweating
- ❑ Weakness
- ❑ Weight loss

Eyes
- ❑ Blurred vision
- ❑ Eye burning
- ❑ Eye discharge
- ❑ Eye itching
- ❑ Eye pain
- ❑ Eye redness
- ❑ Eye swelling
- ❑ Vision changes

ENT/Mouth
- ❑ Ear drainage
- ❑ Ear pain/pressure
- ❑ Head trauma
- ❑ Hearing loss
- ❑ Nasal congestion
- ❑ Nasal drainage
- ❑ Ringing in ears
- ❑ Sinus pressure
- ❑ Sore throat
- ❑ Tongue swelling
- ❑ Toothache

Cardiovascular
- ❑ Angina
- ❑ Chest pain/discomfort
- ❑ Murmur
- ❑ Palpitations

Respiratory
- ❑ Asthma
- ❑ Cough
- ❑ Frequent URI
- ❑ Shortness of breath
- ❑ Wheezing

Gastrointestinal
- ❑ Abdominal pain
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Cramping
- ❑ Diarrhea
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Nausea
- ❑ Rectal bleeding/pain
- ❑ Vomiting

Genito-Urinary
- ❑ Dysuria
- ❑ Hematuria
- ❑ Urinary frequency
- ❑ Urinary urgency
- ❑ Vaginal bleeding
- ❑ Vaginal discharge
- ❑ Vaginal itching
- ❑ Vaginal pain

Muscular/Skeletal
- ❑ Back pain
- ❑ Joint pain
- ❑ Muscle spasm
- ❑ Muscle weakness
- ❑ Stiffness
- ❑ Swelling

Skin/Breast
- ❑ Abrasion
- ❑ Abscess
- ❑ Breast lump
- ❑ Discharge/drainage
- ❑ Erythema (redness)
- ❑ Itch
- ❑ Laceration
- ❑ Rash
- ❑ Rash- allergic
- ❑ Skin sore

Hema/Lymph
- ❑ Bleeding
- ❑ Lymph node pain
- ❑ Lymph node swelling
- ❑ Slow to heal

Allergy/Immun
- ❑ Hives
- ❑ Itchy eyes
- ❑ Itchy skin
- ❑ Sneezing
- ❑ Watery eyes

Neurologic
- ❑ Dizziness
- ❑ Fainting
- ❑ Headache
- ❑ Loss of consciousness
- ❑ Numbness/tingling
- ❑ Speech difficulties
- ❑ Tremors

Psych
- ❑ Anxiety
- ❑ Depression
- ❑ Insomnia

MEDICATIONS you are currently taking

_____

_____

ALLERGIES/REACTION

_____

_____

WOMEN ONLY

Date of last menstrual _____ Are you pregnant? _____ Breastfeeding? _____

Information to be filled out by Medical Staff ONLY:

TEMP _____ BP _____/_____ P _____ WT _____ HT _____ O2 _____ RR _____

Social History **Circle any that apply and write how frequent.**	
Alcohol	
Tobacco	
E-Cig Use	
Drugs	
Smoking	
Exercise	
Other:	

Family & Personal Health History						
Relation	**Age**	**State of Health**	**Age of Death**	**Cause of Death**	**Circle if your blood relatives have had any of the following:**	
Father					**Disease**	**Relationship**
Mother					Arthritis, Gout	
Brothers					Cancer	
Sisters					Chemical Dependency	
Maternal GM					Heart Disease, Stroke	
Maternal GF					High BP	
Paternal GM					Kidney Disease	
Paternal GF					Tuberculosis	
					Other:	

Surgeries	
Procedure	**Year**

Circle conditions you currently have or have had in the past year:				
AIDS	Cancer	Heart Disease	Measles	Stroke
Alcoholism	Chemical Dependency	Hepatitis	Miscarriage	Suicide Attempt
Anemia	Chicken Pox	Hernia	Mononucleosis	Thyroid Problems
Anorexia	Diabetes	High BP	Multiple Sclerosis	Tonsillitis
Arthritis	Emphysema	High Cholesterol	Pacemaker	Tuberculosis
Asthma	Epilepsy	Kidney Disease	Pneumonia	Typhoid Fever
Bleeding Disorders	Gastrointestinal	Liver Disease	Prostate Problem	Ulcers
Breast Lump	Glaucoma	Lung Disease	Psychiatric Care	Urinary Disorders
Bronchitis	Gout	Migraine	STDs	Vaginal Infections
Other:				

I **certify that the above information is correct to the best of my knowledge. I will not hold the doctor/provider or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.**

Patient/Guardian Signature _____ **Date** _____