

HEALTH HISTORY (CONFIDENTIAL)

Name: _____ Today's Date: _____

Reason for Today's Visit: _____

Please check any symptoms below that you **currently have** or are **chronic problems** for you:

- | | | | | | | | | | |
|---|---|--|---|-----------|------|-----------|------|--|--|
| <p>GENERAL</p> <input type="checkbox"/> Weight loss
<input type="checkbox"/> Weight gain
<input type="checkbox"/> Fever
<input type="checkbox"/> Chills
<input type="checkbox"/> Sweats
<input type="checkbox"/> Fatigue | <p>GASTROINTESTINAL</p> <input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Nausea
<input type="checkbox"/> Vomiting
<input type="checkbox"/> Indigestion
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Excessive Gas
<input type="checkbox"/> Bloating
<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Bloody Stool
<input type="checkbox"/> Bowel changes
<input type="checkbox"/> Decreased appetite | <p>SKIN</p> <input type="checkbox"/> Itching/Dry Skin
<input type="checkbox"/> Rash
<input type="checkbox"/> Hives
<input type="checkbox"/> Change in moles
<input type="checkbox"/> Sore that won't heal
<input type="checkbox"/> Pigmentation | <p>HEMATOLOGICAL/
LYMPHATIC</p> <input type="checkbox"/> Bruising easily
<input type="checkbox"/> Bleeding disorder
<input type="checkbox"/> Swollen lymph nodes | | | | | | |
| <p>EYES</p> <input type="checkbox"/> Vision changes
<input type="checkbox"/> Blurry vision
<input type="checkbox"/> Glasses/contacts | <p>BREAST</p> <input type="checkbox"/> Breast lump
<input type="checkbox"/> Nipple discharge
<input type="checkbox"/> Breast pain
<input type="checkbox"/> Previous biopsy
<input type="checkbox"/> Breast cancer
<input type="checkbox"/> Implants | <p>Date of last menstrual period: _____</p> <p>Birth Control Method: _____</p> <p>Date of last pap smear: _____
-Result: _____</p> <p>Have you had a mammogram?
-When? _____
-Result: _____</p> <p>Have you had a Colonoscopy?
-When? _____
-Result: _____</p> <p>Have you had a Bone Density Study (DEXA)?
-When? _____
-Result: _____</p> <p>Are you pregnant? _____</p> <p>-Total number of pregnancies: _____
-Number of children: _____</p> | | | | | | | |
| <p>EAR/NOSE/THROAT</p> <input type="checkbox"/> Headaches
<input type="checkbox"/> Ear Pain
<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Hay fever/Allergies
<input type="checkbox"/> Sinus infections
<input type="checkbox"/> Ulcers/Cold Sores | <p>GENITOURINARY</p> <input type="checkbox"/> Abnormal Pap Smear
<input type="checkbox"/> Heavy periods
<input type="checkbox"/> Painful periods
<input type="checkbox"/> Irregular periods
<input type="checkbox"/> Painful intercourse
<input type="checkbox"/> Vaginal dryness
<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Bleeding after intercourse
<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Leaking urine
<input type="checkbox"/> Painful urination
<input type="checkbox"/> Frequent urination
<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> PMS/Mood Swings | <p>NEUROLOGICAL</p> <input type="checkbox"/> Dizziness
<input type="checkbox"/> Dizziness Problems
<input type="checkbox"/> Seizures
<input type="checkbox"/> Numbness
<input type="checkbox"/> Fainting | | | | | | | |
| <p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest Pain
<input type="checkbox"/> Shortness of breath laying down
<input type="checkbox"/> Shortness of breath with exertion
<input type="checkbox"/> Swelling of ankles
<input type="checkbox"/> Palpitations
<input type="checkbox"/> Irregular heartbeat
<input type="checkbox"/> Rapid heartbeat
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Varicose veins | <p>PSYCHIATRIC</p> <input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Crying
<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Insomnia | <p>ENDOCRINE</p> <input type="checkbox"/> Hot flashes
<input type="checkbox"/> Night sweats
<input type="checkbox"/> Hair loss
<input type="checkbox"/> Hypothyroid
<input type="checkbox"/> Hyperthyroid
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heat/Cold Intolerance | | | | | | | |
| <p>RESPIRATORY</p> <input type="checkbox"/> Difficulty breathing
<input type="checkbox"/> Wheezing
<input type="checkbox"/> Cough
<input type="checkbox"/> Coughing up blood | <p>MUSCLE/JOINT/BONE</p> <p style="text-align: center;">Circle if pain or weakness in:</p> <table border="0" style="width: 100%;"> <tr> <td>Arms/Hands</td> <td>Back</td> </tr> <tr> <td>Legs/Feet</td> <td>Neck</td> </tr> <tr> <td>Shoulders</td> <td>Hips</td> </tr> </table> | Arms/Hands | Back | Legs/Feet | Neck | Shoulders | Hips | | |
| Arms/Hands | Back | | | | | | | | |
| Legs/Feet | Neck | | | | | | | | |
| Shoulders | Hips | | | | | | | | |

Please check any conditions or diagnoses you **have or have had in the past**:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS
<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Anemia
<input type="checkbox"/> Anorexia
<input type="checkbox"/> Appendicitis
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Bulimia
<input type="checkbox"/> Cancer
<input type="checkbox"/> Cataracts
<input type="checkbox"/> Chlamydia | <input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Goiter
<input type="checkbox"/> Gonorrhea
<input type="checkbox"/> Gout
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Hernia
<input type="checkbox"/> Herpes | <input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Measles
<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Miscarriage
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Mumps
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Polio
<input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Stroke
<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Venereal Disease |
|---|--|---|---|

MEDICATIONS: Please list **ALL** medications you take regularly -- including prescription, over the counter, vitamins and herbals:

ALLERGIES: Please list the medication, food, or substance and the reaction you had:

HEALTH HISTORY (page 2)

(CONFIDENTIAL)

PAST MEDICAL HISTORY

Pregnancy History:

Hospitalizations/Surgeries/Major Illnesses or Injuries:

Year	Baby's Sex	Complications during pregnancy or delivery, if any	Year	Type of surgery, reason for hospitalization, or diagnosis

Have you ever had a blood transfusion? **Y** **N** If yes, approximate dates and reason: _____

SOCIAL HISTORY

Health Habits:

Exposures:

Please indicate <i>if</i> and <i>amounts</i> used:		What is your occupation?					
Tobacco		Are you exposed to:					
Alcohol		Y	N	Heavy Lifting	Y	N	Car Exhaust
Drugs		Y	N	Hazardous substances	Y	N	Chemicals
Caffeine		Do you exercise? Y N					
Other		Days per week:		Type of exercise:			

FAMILY HISTORY

Please complete information about your family:

Blood relatives have any of the following:

Relationship	Present Age	State of Health	Age at Death	Cause of Death	Disease	Check if yes	Relationship to you
Father					Diabetes	<input type="checkbox"/>	
Mother					Heart Disease	<input type="checkbox"/>	
Brothers					Stroke	<input type="checkbox"/>	
					Blood Clots	<input type="checkbox"/>	
					Blood Pressure	<input type="checkbox"/>	
					High Cholesterol	<input type="checkbox"/>	
Sisters					Breast Cancer	<input type="checkbox"/>	
					Uterus Cancer	<input type="checkbox"/>	
					Ovary Cancer	<input type="checkbox"/>	
					Fibroids	<input type="checkbox"/>	
					Endometriosis	<input type="checkbox"/>	

I certify that the above information is true and correct to the best of my knowledge. I agree not to hold Dr. Moser or any member of her staff responsible for errors or omissions that I may have made in the completion of this form.

Signature

Date

Reviewed By

Date