MARY MCDONALD, M.D., S.C.
HEALTH HISTORY FORM

Date: _____

Patient name: _____ Date of Birth: _____

1. **Describe the reason for your visit:**

_____

_____

2**. Past History:**

Surgical – Check all that apply

□ Appendix	□ Breast	□ Spine/neck
□ Gallbladder	□ Heart	□ Brain
□ Colon	□ Hip	□ Hysterectomy
□ Stomach	□ Knee	□ Ovaries removed
□ Hernia	□ Hand	□ Prostate
□ Thyroid	□ Foot	□ Tonsillectomy

Other:

_____

_____

Past Medical History – Have you ever been DIAGNOSED with any of the following?

Please circle YES or NO.

Arthritis	NO YES	Crohn's Disease	NO YES	
Asthma	NO YES	Ulcerative Colitis	NO YES	
Lung Disease	NO YES	Heartburn/Reflux	NO YES	
Thyroid Disease	NO YES	Peptic Ulcer Disease	NO YES	
Diabetes	NO YES	H. pylori Infection	NO YES	
High Blood Pressure	NO YES	Hepatitis Infection	NO YES	If yes, Type A, B, or C
High Cholesterol	NO YES	Liver Disease	NO YES	
Heart Attack	NO YES	Gallstones	NO YES	
Coronary Artery Disease	NO YES	Diverticular Disease	NO YES	
Stroke	NO YES	Colon polyps	NO YES	
Cancer (Type)_____	NO YES	Hemorrhoids	NO YES	
Kidney Disease	NO YES	Pancreatic Disease	NO YES	
Anxiety/Depression	NO YES	HIV Infection	NO YES	
Sleep Apnea	NO YES	Blood Transfusion	NO YES	If yes, what year? _____
Anemia	NO YES	Irritable Bowel	NO YES	
Seizure Disorder	NO YES	Tuberculosis	NO YES	
Autoimmune Disease	NO YES	OTHER: _____		

Have you ever had a colonoscopy? □ YES □ NO

If yes, when: _____

If yes, were polyps removed? _____

(CONTINUED ON OTHER SIDE)

3**. Allergies to Medications:** Please list the medication and type of reaction

Medication:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

4**. Medications** (Please include any over the counter medications you take such as aspirin, other pain relievers, vitamins, fiber supplements, and herbal supplements):

Name	**Strength**	**How Often**

5**. Family History:** Please fill in: **F**=father **M**=mother **B**=brother **S**=sister **D**=daughter **S**=son

Colon Cancer _____	Crohn's Disease _____	Ulcerative Colitis _____
Breast cancer _____	Diabetes _____	Heart Disease _____
High Blood Pressure _____	Liver Disease _____	Mental Illness _____
Autoimmune Disease _____		

Other: _____

6**. Social History:**

Occupation: _____
Marital Status: Single Married Significant Other
Number of Children: _____ Ages: _____

If you answer yes to any of the following, please indicate how much per day:
Smoke _____pack/day Drink alcohol _____drinks/day
Drink coffee _____cups/day Drink soda _____cans/day

Recreational drug use past or present? If yes, Type: _____ When: _____

Tattoo placement? If yes, when?_____

Patient Name: _____ Date of Birth: _____

REVIEW OF BODY SYSTEMS

Do you **CURRENTLY** have any of the following: (If yes, check the box.)

GENERAL
Usual weight: _____
Height: _____
□ Weight gain
□ Weight loss
□ Fatigue
□ Fever
□ Weakness

EYES
□ Glasses/Contacts
□ Vision changes
□ Eye pain
□ Glaucoma
□ Cataracts

EARS/NOSE/THROAT
□ Decreased hearing
□ Ear ringing
□ Ear pain
□ Sinus pain
□ Nose bleeds
□ Dry mouth
□ Mouth ulcers
□ Hoarseness
□ Throat pain
□ Throat swelling

CARDIOVASCULAR
□ Chest pain
□ Rapid heartbeat
□ Palpitations
□ Irregular pulse
□ Leg/ankle swelling
□ Leg pain with walking
□ Faintness
□ Blood clots
□ Shortness of breath

RESPIRATORY
□ Cough
□ Difficulty breathing
□ Painful breathing
□ Wheezing

GASTROINTESTINAL
□ Abdominal pain
□ Pain with eating
□ Appetite changes
□ Nausea
□ Vomiting
□ Vomiting blood
□ Heartburn
□ Difficulty swallowing
□ Gas/bloating
□ Change in bowel habits
□ Diarrhea
□ Constipation
□ Rectal bleeding

GENITOURINARY
□ Frequent urination
□ Painful urination
□ Blood in urine
□ Incontinence
□ Kidney stones

Women
- □ Vaginal discharge
- □ Menstrual irregularities

Men
- □ Prostate problems
- □ Testicular pain/mass

MUSCULOSKELETAL
□ Joint pain
□ Joint swelling
□ Stiffness
□ Muscle pain
□ Muscle weakness
□ Decreased range of motion

SKIN
□ Rash
□ Itching
□ Nail changes
□ Skin color changes
□ New lesions

NEUROLOGICAL
□ Dizziness/Vertigo
□ Headaches
□ Numbness/Tingling
□ Fainting
□ Seizures
□ Tremor
□ Weakness
□ Memory loss

PSYCHIATRIC
□ Depression
□ Anxiety
□ Mood swings
□ Change in sleeping patterns
□ Suicidal thoughts

OTHER: _____

PHYSICIAN REVIEWED
