

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

- | | | |
|--------------------------------------|---------------------------------|--|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Breast | <input type="checkbox"/> Spine/neck |
| <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Heart | <input type="checkbox"/> Brain |
| <input type="checkbox"/> Colon | <input type="checkbox"/> Hip | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Knee | <input type="checkbox"/> Ovaries removed |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Hand | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Foot | <input type="checkbox"/> 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

OTHER: _____

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

PHYSICIAN REVIEWED

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