HEALTH HISTORY

PATIENT NAME _____ BIRTHDATE _____/_____/_____ PATIENT # _____

To help us meet your entire healthcare needs, please fill out **both sides** of this form completely in ink. This is a confidential record of your Medical history and will be kept in this office.

Today's date _____
Place of birth _____
Highest level in school _____
Occupation _____
Previous occupations _____
Marital status _____
Hobbies _____
Exercise/recreation _____
Habits:
Smoking (type & amount per day) _____
If former smoker, date quit _____
Alcohol (type & amount per day) _____
Caffeine (type & amount per day) _____
Street drugs (type & amount per day) _____
Usual weight _____
Date of last dental exam _____
Please list all allergies (foods, drugs, environment)
_____
_____
_____

When was your last physical exam? _____
Name of doctor _____ Phone _____
please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred: none
_____
_____
_____
_____

Please list all medicines you are currently taking (including non-prescription drugs):
_____
_____
_____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred): none
_____
_____
_____

Chief Complaints
Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:
_____
_____

Past Medical History
Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Migraine headaches	no	yes	Hives or Eczema	no	yes
Mumps	no	yes	Tuberculosis	no	yes	AIDS or HIV+	no	yes
Chickenpox	no	yes	Diabetes	no	yes	Infectious Mono	no	yes
Whooping Cough	no	yes	Cancer	no	yes	Bronchitis	no	yes
Scarlet Fever	no	yes	Polio	no	yes	Mitral Valve Prolapse	no	yes
Diphtheria	no	yes	Glaucoma	no	yes	Stroke	no	yes
Smallpox	no	yes	Hernia	no	yes	Hepatitis	no	yes
Pneumonia	no	yes	Blood or Plasma	no	yes	Ulcer	no	yes
Rheumatic Fever	no	yes	transfusions			Kidney Disease	no	yes
Heart Disease	no	yes	Back trouble	no	yes	Thyroid Disease	no	yes
Arthritis	no	yes	High or low blood	no	yes	Bleeding tendency	no	yes
Venereal Disease	no	yes	pressure			Any other disease	no	yes
Anemia	no	yes	Hemorrhoids	no	yes	(please list) _____		
Bladder Infections	no	yes	Date of last chest x-ray _____			_____		
Epilepsy	no	yes	Asthma	no	yes	_____		

Family History
Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

			Relationship				Relationship
Cancer	no	yes		Stroke	no	yes	
Tuberculosis	no	yes		Epilepsy	no	yes	
Diabetes	no	yes		Allergies	no	yes	
Heart Disease	no	yes		Anemia	no	yes	
High blood pressure	no	yes		Bleeding tendency	no	yes	

Family History (cont.)

Relationship	Present age or age of death	If living, health (good, fair, poor) If deceased, cause of death
Father		
Mother		
Siblings		
Spouse		
Children		

Asthma	no	yes						
Chronic lung disease	no	yes						
Drug or alcohol problem	no	yes						
Mental Illness	no	yes						
Leukemia	no	yes						
Migraine headaches	no	yes						
Obesity	no	yes						
Thyroid Disease	no	yes						
Ulcer	no	yes						
Depression	no	yes						
High Cholesterol.	no	yes						
Kidney Disease.	no	yes						
Glaucoma	no	yes						
Gout	no	yes						

Do you have now or have you had within the past year:
(Circle "no" or "yes", leave blank if uncertain)

Weakness or paralysis	no	yes	Bloody sputum	no	yes	Joint pain or stiffness	no	yes
Tire easily or weakness	no	yes	Wheezing	no	yes	Swollen joints	no	yes
Recent weight changes	no	yes	Chest pain or discomfort	no	yes	Muscle cramps or spasms	no	yes
Change in appetite	no	yes	Purple fingers or lips	no	yes	Sleeplessness	no	yes
Sensitivity to cold or heat	no	yes	Swelling of hands, feet or ankles	no	yes	Seizures	no	yes
Persistent fever	no	yes	Difficulty in breathing	no	yes	Depression	no	yes
Night sweats or hot flashes	no	yes	Palpitations or fluttering of the heart	no	yes	Memory loss	no	yes
Skin rash	no	yes	Leg cramps on walking or at night	no	yes	Poor coordination	no	yes
Skin trouble or change	no	yes	Enlarged veins	no	yes	Dizziness or fainting spells	no	yes
Change in nails or hair	no	yes	Difficulty swallowing	no	yes	A living will or advance		
Headaches	no	yes	Heartburn	no	yes	directive	no	yes
Easy bleeding or bruising	no	yes	Frequent belching	no	yes	**Men only:**		
Double vision	no	yes	Abdominal cramping	no	yes	Discharge from penis	no	yes
Blurred vision	no	yes	Nausea	no	yes	Pain or lump in testicles	no	yes
Eye pain	no	yes	Vomiting	no	yes	Impotence	no	yes
Infected eyes	no	yes	Vomited or coughed up blood	no	yes	**Women only:**		
Wear glasses/contacts	no	yes	Chronic diarrhea	no	yes	Age period began _____		
When was your last eye exam _____			Chronic constipation	no	yes	How many days do periods last? _____		
Ringing in the ears	no	yes	Rectal bleeding	no	yes	How many days between periods? ____		
Discharge from ears	no	yes	Black tarry stools	no	yes	Is the flow heavy?	no	yes
Ear pain	no	yes	Dark urine	no	yes	Do you bleed or spot	no	yes
Decrease in hearing	no	yes	Yellow jaundice	no	yes	between periods?		
Frequent nosebleeds	no	yes	Frequent urination (day)	no	yes	Do you have pain or cramps?	no	yes
Frequent colds	no	yes	Frequent urination (night)	no	yes	Date of last period? _____		
Sinus trouble	no	yes	Increase in thirst	no	yes	Date of last pelvic exam? _____		
Loss of smell	no	yes	Painful urination	no	yes	Date of last mammogram? _____		
Persistent hoarseness	no	yes	Leakage of urine	no	yes	Any itching in vaginal area?	no	yes
Sore throat	no	yes	Difficulty in starting urine	no	yes	Pain with intercourse?	No	yes
Sore tongue or gums	no	yes	Blood in urine	no	yes	Type of birth control used? _____		
Lump or discharge			Lack of sex drive	no	yes	Number of pregnancies _____		
from breast	no	yes	Hemorrhoids	no	yes	Number of full term births _____		
Chronic or frequent cough	no	yes	Backaches	no	yes	Number of pre-term births _____		
Shortness of breath	no	yes						

X_____ _____

Signature of patient or parent if minor Date

ROMEO MEDICAL CLINIC, INC.