

# PERSONAL HEALTH HISTORY



## INTERNAL MEDICINE & ADULT PRIMARY CARE

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NAME		BIRTHDATE		DATE		
CURRENT ADDRESS: City: _____ State: _____ Zip: _____				PHONE: home: work: cell:		
OCCUPATION/ EMPLOYER			If retired Date: _____		INSURANCE	
<b>MEDICATIONS</b>		<b>ALLERGIES</b>	<b>LIFESTYLE</b>		<b>HEALTH MAINTENANCE</b>	
			<input type="checkbox"/> Alcohol _____ oz. per week		<b>Vaccinations</b> year of last	<b>Test / Exam</b> year of last
			<input type="checkbox"/> Coffee/Tea _____ cups per day		Tetanus / Td	Complete Physical
			<input type="checkbox"/> Smoking _____ cig/day		Influenza (FLU)	Cholesterol
			_____ #years _____ year quit		Pneumonia	Blood test
			<input type="checkbox"/> Exercise		Hepatitis A	Colonoscopy
			<input type="checkbox"/> Street drugs		Hepatitis B	Chest Xray
			<input type="checkbox"/> Recreation		Other	EKG
<b>PAST MEDICAL HISTORY (Hospitalization, Chronic Medical Conditions)</b>				<b>PREVIOUS SURGERIES</b>		
1		5		1	5	
2		6		2	6	
3		7		3	7	
4		8		4	8	
<b>FAMILY HISTORY</b>	<b>Age: Present or at Death</b>	<b>If living, health (good, fair, poor) If deceased, cause of death</b>		<b>Relationship</b>	<b>Age: Present or at Death</b>	<b>If living, health (good, fair, poor) If deceased, cause of death</b>
Mother				Brother / Sister		
Father				Brother / Sister		
Grandmother				Brother / Sister		
Grandfather				Brother / Sister		
Grandmother				Brother / Sister		
Grandfather				Brother / Sister		
Son / Daughter				Brother / Sister		
Son / Daughter				Brother / Sister		
Son / Daughter				Brother / Sister		
Son / Daughter				Brother / Sister		
<b>FAMILY HISTORY</b> If a blood relative has suffered any of the following – please check the box and indicate which relative						
<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Thyroid Disease		<input type="checkbox"/> Arthritis		<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Migraine		<input type="checkbox"/> Hay fever		<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Mental Illness		<input type="checkbox"/> Asthma		<input type="checkbox"/> Stroke		<input type="checkbox"/> Cancer
<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Anemia		<input type="checkbox"/> Hypertension		<input type="checkbox"/> Aneurysm
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Osteoporosis		<input type="checkbox"/> Lipid disorder		

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## HARRISON HealthPartners

NAME		DATE
<b>FEMALE HEALTH HISTORY (Females Only)</b>		
<b>Menstrual flow:</b>	Number of:	<input type="checkbox"/> Menopause    Age at onset _____
<input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain/Cramps	Pregnancies _____    Abortions _____	Date of last PAP test
Days of flow _____ Length of cycle _____	Miscarriages _____    Live births _____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Date – 1 <sup>st</sup> day of last period	Birth control method	Date of last Mammogram
<input type="checkbox"/> Pain / Bleeding during or after sex	B.C. pill (name)	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
<b>MEDICAL HISTORY</b>		
<b>MAIN PROBLEMS:</b>		
<input type="checkbox"/> Decreased hearing	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Ringing in ear	<input type="checkbox"/> Heartburn <input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Seizures <input type="checkbox"/> Stroke
<input type="checkbox"/> Ear infections - <i>frequent</i>	<input type="checkbox"/> <i>Persistent</i> nausea / Vomiting	<input type="checkbox"/> Tremor / hands shaking
<input type="checkbox"/> Dizzy spells <input type="checkbox"/> Fainting spells	<input type="checkbox"/> Abdominal pain - <i>chronic</i>	<input type="checkbox"/> Numbness / tingling sensations
<input type="checkbox"/> Failing vision <input type="checkbox"/> Eye pain	<input type="checkbox"/> Gall bladder trouble	<input type="checkbox"/> Headaches - <i>frequent</i>
<input type="checkbox"/> Double or blurred vision	<input type="checkbox"/> Jaundice / Hepatitis	<input type="checkbox"/> Arthritis / Rheumatism
<input type="checkbox"/> Nose bleeds - <i>recurrent</i>	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation	<input type="checkbox"/> Back pain - <i>recurrent</i>
<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Diverticulosis <input type="checkbox"/> Crohn's / Colitis	<input type="checkbox"/> Bone fracture / joint injury
<input type="checkbox"/> Sore throats - <i>frequent</i>	<input type="checkbox"/> Bloody or tarry stools	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Hoarseness - <i>prolonged</i>	<input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia	<input type="checkbox"/> Foot pain <input type="checkbox"/> Gout
<input type="checkbox"/> Hay fever / Allergies	Urination – Overactive Bladder	<input type="checkbox"/> Rashes <input type="checkbox"/> Hives
<input type="checkbox"/> Pneumonia / Pleurisy	<input type="checkbox"/> Overnight > than twice	<input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema
<input type="checkbox"/> Bronchitis / Chronic cough	<input type="checkbox"/> More than 8 times / 24 hours	<input type="checkbox"/> Sleeping or concentration difficulty
<input type="checkbox"/> Asthma / Wheezing	<input type="checkbox"/> Urgency to urinate <input type="checkbox"/> with leakage	<input type="checkbox"/> Depression <input type="checkbox"/> Nervousness
<input type="checkbox"/> Shortness of breath:	<input type="checkbox"/> Decrease in force/flow <input type="checkbox"/> Painful	<input type="checkbox"/> Agitation <input type="checkbox"/> Memory loss
<input type="checkbox"/> on exertion <input type="checkbox"/> lying flat	<input type="checkbox"/> Stress incontinence-urine leakage	<input type="checkbox"/> Moodiness <input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Chest pain	with exercise/ movement	<input type="checkbox"/> Phobias <input type="checkbox"/> Mental illness
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Feelings of worthlessness
<input type="checkbox"/> Heart murmur <input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Urine infections - <i>frequent</i>	<input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Irregular pulse <input type="checkbox"/> Palpitations	<input type="checkbox"/> Sexually transmitted diseases	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Polio <input type="checkbox"/> Mumps
<input type="checkbox"/> Leg pain – <i>when walking</i>	<input type="checkbox"/> Weight-loss <input type="checkbox"/> Gain - <i>recent</i>	<input type="checkbox"/> Measles <input type="checkbox"/> German Measles
<input type="checkbox"/> Varicose veins / Phlebitis	<input type="checkbox"/> Anemia <input type="checkbox"/> Bruise easily	<input type="checkbox"/> Tuberculosis <input type="checkbox"/> Herpes
<input type="checkbox"/> Cold numb feet	<input type="checkbox"/> Blood transfusions	<input type="checkbox"/> Aids / HIV
<input type="checkbox"/> Loss of appetite - <i>recent</i>	<input type="checkbox"/> Cancer <input type="checkbox"/> Chronic fatigue	Hair loss: <input type="checkbox"/> progressive <input type="checkbox"/> recent
<b>CURRENT HEALTH CONCERNS</b>		
1	5	
2	6	
3	7	
4	8	