Health History

Manhan Internal Medicine

Patient Name_____ Birthday _____/_____/_____ Patient # _____

To help us meet all of your 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: _____

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

Habits:

Smoking (type and amount per day) _____
If former smoker, date quit _____
Alcohol (type & amount per week) _____
Caffeine (type & amount per day) _____
Street drugs (type & amount per day) _____
Usual weight: _____
Date of last dental exam: _____
Please list all allergies (food, drugs, and environment)
_____
_____
_____

please list all medicines you are currently taking (Include nonprescription drugs): [ ] none
_____
_____
_____
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 Infection	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	Present age, or age of death
Asthma	no	yes	_____	Father _____
Chronic lung disease	no	yes	_____	Mother _____
Drug or alcohol problem	no	yes	_____	Siblings _____
Mental Illness	no	yes	_____	_____
Leukemia	no	yes	_____	_____
Migraine Headaches	no	yes	_____	_____
Obesity	no	yes	_____	_____
Thyroid disease	no	yes	_____	Spouse _____
Ulcer	no	yes	_____	Children _____
Depression	no	yes	_____	_____
High Cholesterol	no	yes	_____	_____
Kidney disease	no	yes	_____	_____
Glaucoma	no	yes	_____	_____
Gout	no	yes	_____	_____

Did 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 changes	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 Directive	no	yes
Headaches	no	yes	Heartburn	no	yes	**Men Only**:		
Easy bleeding or bruising	no	yes	Frequent belching	no	yes	Discharge from penis? No yes		
Double vision	no	yes	Abdominal cramping	no	yes	Pain or lump on the testicles? No yes		
Blurred vision	no	yes	Nausea	no	yes	Impotence? No yes		
Eye pain	no	yes	vomiting	no	yes	**Women only:**		
Infected eyes	no	yes	vomit or cough up blood	no	yes	Age period began _____		
Do you wear glasses or contacts	no	yes	chronic diarrhea	no	yes	how many days do periods last? _____		
When was your last eye exam	no	yes	chronic constipation	no	yes	how many days between periods? _____		
Ringing in the ears	no	yes	rectal bleeding a yes I			s the flow heavy? No yes		
Discharge from ears	no	yes	Black tarry stool	no	yes	Do you bleed or spot between periods? No yes		
Ear pain	no	yes	Dark urine	no	yes	Do you have pain pr cramps? No yes		
Decrease in hearing	no	yes	Yellow jaundice	no	yes	Date of last period? _____		
Frequent nosebleeds	no	yes	frequent urination (day)	no	yes	Date of last pelvic exam? _____		
Frequent Colds	no	yes	frequent urination (night)	no	yes	Date of last mammogram? _____		
Sinus trouble	no	yes	Increase in thirst	no	yes	any itching in your vaginal area? No yes		
Loss of smell	no	yes	painful urination	no	yes	Pain with intercourse? No yes		
Persistent hoarseness	no	yes	Leakage of urine	no	yes	Type of birth control used? _____		
Sore throat	no	yes	Difficulty in starting urine	no	yes	Number of pregnancies _____		
Sore tongue or gums	no	yes	Blood in urine	no	yes	Number of full term births _____		
Lump or discharge from breast	no	yes	Lack of sex drive	no	yes	Number of preterm births _____		
Chronic or frequent cough	no	yes	Hemorrhoids	no	yes			
Shortness of breath	no	yes	Backaches	no	yes			

X_____ _____

Signature of patients