

HEALTH INFORMATION SHEET

The following information is very important to your health. Please take the time to fully and accurately fill out this form

NAME _____ DATE OF BIRTH _____ TODAY'S DATE _____
 Weight: _____ Height: _____

Past Medical Information (Check Yes or No)

Diabetes	Yes__No__	Heart Attack	Yes__No__	Stroke	Yes__No__
Heart Failure	Yes__No__	Heart Murmur	Yes__No__	Heart Valve ds	Yes__No__
High Blood Pres	Yes__No__	Asthma	Yes__No__	Bronchitis	Yes__No__
Peptic Ulcer	Yes__No__	Hepatitis A/B/C	Yes__No__	Glaucoma	Yes__No__
Skin Cancer	Yes__No__	Bleeding ds	Yes__No__	Immune ds	Yes__No__
Head Trauma	Yes__No__	HIV/AIDS	Yes__No__	Blood Transfusio	Yes__No__
Seizures	Yes__No__	Depression	Yes__No__	Thyroid ds	Yes__No__
Other (Specify) _____					

Surgeries (Specify all operations and dates): _____

List ALL **MEDICATIONS**: _____

ALLERGIES: Medications _____ Reactions _____

Family History:

Diabetes	Yes__No__	Heart Disease	Yes__No__	Hypertension	Yes__No__
Bleeding ds	Yes__No__	Cancer	Yes__No__	Hearing Loss	Yes__No__

Social History:

Occupation _____	Noise Exposure	Yes__No__	Allergen Exposure	Yes__No__
Married	Yes__No__	Children	Yes__No__	Ages _____
Smoking	Yes__No__	How Much _____	How Long _____	
Alcohol	Yes__No__	How Much _____	How Long _____	
IV Drug Use	Yes__No__	How Much _____	How Long _____	
AIDS/HIV Risks _____				

Review of Symptoms

Chest Pain	Yes__No__	Palpitation	Yes__No__	Ankle Swelling	Yes__No__
Short of Breath	Yes__No__	Wheezing	Yes__No__	Cough/Sputum	Yes__No__
Abdominal Pain	Yes__No__	Nausea/Vomiting	Yes__No__	Diarrhea/Constip	Yes__No__
Jaundice	Yes__No__	Rectal Bleeding	Yes__No__	Blood in Urine	Yes__No__
Difficulty Urine	Yes__No__	Painful Urination	Yes__No__	Flank Pain	Yes__No__
Frequent Urine	Yes__No__	Hesitancy	Yes__No__	Impotency	Yes__No__
Female Bleeding	Yes__No__	Pap Smear	Yes__No__	Pregnancy	Yes__No__
Heat Intolerance	Yes__No__	Cold Intolerance	Yes__No__	Constant Thirst	Yes__No__
Headache	Yes__No__	Blackouts	Yes__No__	Weakness	Yes__No__
Tremors	Yes__No__	Skin Lesions	Yes__No__	Blurred Vision	Yes__No__
Glasses/Contacts	Yes__No__	Fever	Yes__No__	Weight Loss	Yes__No__
Fatigue	Yes__No__	Difficulty Swallowing	Yes__No__	Hoarseness	Yes__No__

I attest that the above information is true and correct to the best of my belief

X _____	X _____	X _____	X _____
Patient's Signature	Date		
X _____	X _____	X _____	X _____

Physician/ARNP's Signature

Date

