Patient Name:_____

## CONFIDENTIAL HEALTH HISTORY

The items below may relate to your current condition. In the space provided, please mark whether you have **EVER** had the problem.

**GENERAL**
__Chronic Fever
__Chronic Chills
__Chronic Loss of Sleep
__Chronic Fatigue
__Chronic Nervousness
__Chronic Weight Loss/Gain
__Chronic Allergies
__Chronic Bleeding
__Anemia
__Diabetes
__Cancer
__Thyroid Disease/Goiter
__Alcoholism
__Drug Abuse
__Surgeries
__Medications
_____
__Supplements/Vitamins
_____

**EYE, EAR, NOSE, THROAT**
__Poor Vision
__Eye Pain
__Deafness/Difficulty Hearing
__Chronic Nose Bleeds
__Sinus Problems
__Dental Problems
__Chronic Hoarseness
__Tonsilectomy

**GASTROINTESTINAL**
__Poor Appetite/Digestion
__Difficulty Swallowing
__Belching/Gas
__Frequent Nausea
__Vomiting
__Vomiting Blood
__Chronic Abdominal Pain
__Ulcer
__Black and Bloody Stool
__Liver Problems
__Gall Bladder Problems
__Jaundice
__Hernia
__Diarrhea
__Constipation
__Hemorrhoids
__Appendicitis

**MEN ONLY**
__Testicular Swelling/Pain
__Prostate Problems

**RESPIRATORY**
__Difficulty Breathing
__Chronic Cough
__Spitting Phlegm
__Spitting Blood
__Wheezing/Asthma
__Pneumonia
__Tuberculosis

**CARDIOVASCULAR**
__Irregular Heartbeat
__High Blood Pressure
__Pain over Heart
__Ankle Swelling
__Varicose Veins
__Rheumatic Fever
__Stroke

**GENITOUINARY**
__Frequent Urination
__Painful Urination
__Blood In Urine
__Kidney Problems
__Inability to Control Urination
__Difficulty Starting Urine Flow
__Up__times/night to urinate
__Breast Lump/Pain
__Venereal Infection
__Sexual Difficulties

**WOMEN ONLY**
__Painful Periods
__Excessive Flow
__Irregular Cycle
__Vaginal burning/itching
__Hot Flashes
_____Date of Last Pap Test

**SKIN**
__Itching
__Bruise Easily
__Change in Mole(s)
__Skin Cancer

**NEUROLOGIC**
__Weakness
__Twitching
__Tremors
__Headache
__Fainting
__Dizziness
__Convulsions
__Epilepsy
__Numbness/Tingling
__Arm/Leg Pain
__Mental Disorder

**MUSCULOSKELETAL**
__Neck/Stiffness/Pain
__Pain Between Shoulders
__Low Back Pain
__Swollen Joints
__Painful Joints
__Muscle Aches/Soreness
__Spinal Curvature
__Arthritis
__Fractures

**HABITS**
__Smoking(__packs a day)
__Drinking(__drinks wk/month)
__Recreational Drug Use

**EXERCISE**
__None
__1-2 times/week
__3-5 times/week
__6-7 times/week

**FAMILY HISTORY**
__Diabetes
__Thyroid Disease
__Tuberculosis
__Kidney Disease
__High Blood Pressure
__Heart Disease
__Cancer
__Muscle, Bone/Nerve Disease