

HEALTH INFORMATION SHEET

The following information is important to your health. Please take the time to 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 disorder	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		