HEALTH SERVICE SYSTEMS, INC.

PATIENT HISTORY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

To be completed by Patient.

Do you have any of these conditions?

PATIENT MEDICAL HISTORY	No	Yes
Diabetes	☐	☐
Hypertension	☐	☐
Cancer	☐	☐
Stroke	☐	☐
Heart trouble	☐	☐
Arthritis/gout	☐	☐
Convulsions	☐	☐
Bleeding tendency	☐	☐
Venereal disease	☐	☐
Hereditary defects	☐	☐

CONSTITUTIONAL SYMPTOMS	No	Yes
Weight Loss/Weight Gain	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Headaches	☐	☐

EYES	No	Yes
Wear glasses/contact lens	☐	☐
Blurred or double vision	☐	☐
Glaucoma	☐	☐

EARS/NOSE/MOUTH/THROAT	No	Yes
Hearing loss or ringing	☐	☐
Earaches or drainage	☐	☐
Chronic sinus problem	☐	☐
Nose bleeds	☐	☐
Bleeding gums	☐	☐
Sore throat or voice change	☐	☐
Swollen glands in neck	☐	☐

CARDIOVASCULAR	No	Yes
Chest pain	☐	☐
Palpitations	☐	☐
Shortness of breath	☐	☐
Swelling of feet, ankles or hands	☐	☐
High blood pressure	☐	☐

RESPIRATORY	No	Yes
Chronic or frequent coughs	☐	☐
Spitting up blood	☐	☐
Asthma or wheezing	☐	☐

GASTROINTESTINAL	No	Yes
Loss of appetite	☐	☐
Nausea or vomiting	☐	☐
Frequent diarrhea	☐	☐
Constipation	☐	☐
Rectal bleeding or blood in stool	☐	☐
Abdominal pain	☐	☐
Peptic ulcer (stomach or duodenal)	☐	☐
Heartburn	☐	☐

MUSCULOSKELETAL	No	Yes
Joint pain (more than 30 min.)	☐	☐
Joint stiffness or swelling (more than 30 min.)	☐	☐
Muscle pain or cramps	☐	☐
Back pain	☐	☐
Bone fracture/Joint injury	☐	☐

GENITOURINARY	No	Yes
Frequent urination	☐	☐
Burning or painful urination	☐	☐
Blood in urine	☐	☐
Change in force or strain when urinating	☐	☐
Incontinence or dribbling	☐	☐
Kidney stones	☐	☐
Male testicular pain	☐	☐
Female - vaginal discharge	☐	☐
vaginal itching	☐	☐
breast pain/lump/discharge	☐	☐

INTEGUMENTARY (skin, breast)	No	Yes
Rash	☐	☐
Change in skin color	☐	☐
Change in hair or nails	☐	☐
Itching	☐	☐

NEUROLOGICAL	No	Yes
Frequent or recurring headaches	☐	☐
Light headed or dizzy	☐	☐
Convulsions or seizures	☐	☐
Numbness or tingling sensations	☐	☐
Tremors	☐	☐
Stroke	☐	☐
Head injury		

PHYCHIATRIC	No	Yes
Memory loss or confusion	☐	☐
Nervousness	☐	☐
Depression	☐	☐
Insomnia	☐	☐
Mental Illness	☐	☐

ENDOCRINE	No	Yes
Thyroid disease	☐	☐
Excessive thirst or urination	☐	☐
Heat or cold intolerance	☐	☐

HEMATOLOGIC/LYMPHATIC	No	Yes
Bleeding or bruising tendency	☐	☐
Anemia	☐	☐
History of Clots	☐	☐
Past transfusion	☐	☐

ALLERGIC/IMMUNOLOGIC	No	Yes
History of skin reaction or other adverse reaction to:	☐	☐
Penicillin or other antibiotics	☐	☐
Morphine, Demerol, or other narcotics	☐	☐
Novocaine or other anesthetics	☐	☐
Aspirin or other pain remedies	☐	☐
Tetanus antitoxin or other serums	☐	☐
Iodine, methiolate or other antiseptic	☐	☐
	☐	☐

Other drugs/medications: _____

Known food allergies: _____

Immunizations - up to date

_____

_____

Previous Hospitalizations/Surgeries/Serious Injuries When?

Explain: _____

_____

_____

_____