2001 Auburn Hills Pkwy, Ste 801, McKinney, TX 75071

# Health History

**Last name:** ______________________ **First name:** ______________________ **DOB:** ____________

**Reason for your visit today:**

______________________________________________

______________________________________________

______________________________________________

**Personal Medical History**

**Constitutional** *e.g., fever, heat stroke, weight loss, weight gain, unusually tired, etc.*

☐Yes ☐No

Comments: ______________________________________________

**Ear/Nose/Throat** *e.g., hard of hearing, stuffy nose, earache, cough, dry mouth, etc.*

☐Yes ☐No

Comments: ______________________________________________

**Heart (Cardiovascular)** *e.g., high blood pressure, racing pulse, chest pain, unable to exercise, etc.*

☐Yes ☐No

Comments: ______________________________________________

**Lungs (Respiratory)** *e.g., congestion, wheezing, shortness of breath, productive or bloody cough, asthma, etc.*

☐Yes ☐No

Comments: ______________________________________________

**Digestion (Gastrointestinal)** *e.g., stomach upset, diarrhea, constipation, hernia, ulcers, pain/cramps, acid reflux, etc.*

☐Yes ☐No

Comments: ______________________________________________

**Muscles and bones (Musculoskeletal)** *e.g., muscle pain/cramps, joint pain swelling, stiffness, etc.*

☐Yes ☐No

Comments: ______________________________________________

**Urological** *e.g., painful or frequent urination, burning, impotence, incontinence, infections, etc.*

☐Yes ☐No

Comments: ______________________________________________

**Gynecological** *e.g., pregnancies, menstrual problems, ovarian and uterine conditions, etc.*

☐ Yes ☐ No

Comments: ______________________________________________

**Breast** *e.g., cysts, fibroids, pain, numbness, lumps, etc.*

☐Yes ☐No

Comments: ______________________________________________

**Neurological** *e.g., numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc.*

☐Yes ☐No

Comments: ____________________

**Psychiatric** *e.g., depression, anxiety, mood swings, insomnia, hallucinations, disorientation, etc.*

☐Yes ☐No

Comments: ____________________

**Blood/Lymphatic** *e.g., high cholesterol, anemia, blood disorders, leukemia, prolonged bleeding, etc.*

☐Yes ☐No

Comments: ____________________

**Skin** *e.g., itching, rash, infection, ulcer, tumors or growths, warts, excessive dryness, etc.*

☐Yes ☐No

Comments: ____________________

**Cancer**

☐Yes ☐No

Comments: ____________________

**Allergic/Immunologic** *e.g., recurrent infections, hay fever, food allergy, drug sensitivity, hives, redness, itching, etc*

☐Yes ☐No

Comments: ____________________

**Hormones (Endocrine)** *e.g., diabetes, thyroid problems, fatigue, hair loss, hot/cold intolerance, etc.*

☐Yes ☐No

Comments: ____________________

**IF DIABETIC:**

**Doctor and contact information:** ____________________

**Year of diagnosis:** ____________________ **Result/Time of last blood sugar:** ____________________

**Last hemoglobin A1C:** ____________________ **Treatments:** ____________________

**Major illnesses/Hospitalizations**

☐Yes ☐No

Comments: ____________________

**Surgeries**

☐Yes ☐No

Comments: ____________________

## Family History

*(Parents, Siblings, or Grandparents only)*

**Please indicated affected family member(s) next to checked box**

☐ **Kidney Disease**
☐ Diabetes
☐ Cancer
☐ Heart disease
☐ Hypertension
☐ Arthritis
☐ Other:

## PERSONAL SOCIAL HISTORY

**Marital status:** ______________________________

**Living arrangements:** ______________________________

**Have you been exposed to venereal disease/sexually transmitted infection?**

☐ Yes ☐ No

**Are you pregnant?**

☐ Yes ☐ No

**Occupation(s):** ______________________________

**Occupational exposure:**

☐ Yes ☐ No

**Recent travel:**

☐ Yes ☐ No

**Tobacco use**

☐ Never ☐ Current everyday use ☐ Current intermittent use ☐ Former use ☐ Status unknown ☐ Other: ____________

**Alcohol use**

☐ Never ☐ Current everyday use ☐ Current intermittent use ☐ Former use ☐ Status unknown ☐ Other: ____________

**Recreational drug use**

☐ Never ☐ Current everyday use ☐ Current intermittent use ☐ Former use ☐ Status unknown ☐ Other: ____________

**Medications:** *List ALL medications you are CURRENTLY taking. (Include all herbals, vitamins and supplements)*

| Name | Dose | Frequency | Other information |
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**IF MEDICATION LIST GOES BEYOND THE SPACE PROVIDED, THEN PLEASE ATTACH A SEPARATE SHEET**

**Allergies:** *Please list ALL allergies*

| Allergy | Severity | Reaction | Treatment Information |
|---|---|---|---|
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**Preferred pharmacy:**

| Name | Pharmacy Location Number | Address | Phone Number | Fax Number |
|---|---|---|---|---|
| | | | | |

**Signature** ______________________________ **Date** ____________

**Printed name** ______________________________