

Health History

Patient Name: _____

Date: _____

Age: _____

Date of Birth: _____

Review of Symptoms

Check symptoms you currently have or have had in the last year.

CONSTITUTIONAL

- Chills
- Dizziness
- Fainting
- Fever
- Loss of sleep
- Loss of weight
- Sweats

MUSCULOSKELETAL

- Pain, weakness, numbness in:
- Arms, hands
- Legs, feet
- Head, neck
- Back

GENITO-URINARY

- Blood in urine
- Bladder problems
- Pain on urination
- Difficulty urinating

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart rate
- Low blood pressure
- Poor circulation
- Swelling of ankles
- Varicose veins

EYES

- Blurred vision
- Crossed eyes
- Double vision
- Visual flashes
- Visual halos
- Loss of vision

EARS/NOSE/THROAT

- Bleeding gums
- Difficulty swallowing
- Earache
- Ear discharge
- Hoarseness
- Hearing loss
- Nosebleeds
- Ringing in ears

SKIN

- Bruise easily
- Hives
- Itching
- Change in mole
- Rash
- Scars
- Sores that won't heal

RESPIRATORY

- Shortness of breath
- Chronic cough
- Coughing blood
- Wheezing
- Lung infections

NEUROLOGICAL

- Headache
- Nervousness
- Numbness
- Weakness

PSYCHIATRIC

- Depression
- Suicide attempts
- Alcohol abuse
- Drug abuse

ENDOCRINE

- Low thyroid
- High thyroid
- Thyroid nodule
- Diabetes
- Adrenal disorder
- Pituitary disorder

DOCTOR COMMENTS:

Past Medical History

Check conditions you currently have or have had in the past.

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Bleeding disorders
- Breast lump
- Bronchitis
- Cancer
- Cataracts

- Chicken pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gout
- Heart disease
- Hepatitis
- Hernia
- Herpes

- High cholesterol
- Kidney disease
- Liver disease
- Measles
- Migraine headache
- Miscarriage
- Mononucleosis
- Multiple sclerosis
- Mumps
- Pacemaker
- Pneumonia

- Prostate problem
- Psychiatric disorder
- Rheumatic fever
- Scarlet fever
- Stroke
- Suicide attempt
- Thyroid problems
- Tonsillitis
- Tuberculosis
- Ulcers

Patient Name _____

Date of Birth _____ Date _____

Austin Allergy Associates
3303 Northland Drive, Suite 301, Austin, TX 78731
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Past Medical History

Hospitalizations:

Year	Hospital	Condition

Surgeries:

Year	Hospital	Condition

Social History

Habits:

Occupational:

Y/N	How much?
	Caffeine
	Tobacco
	Drugs
	Other:

Occupation/school: _____
 Work or school missed due to allergies/asthma/sinusitis: _____
 Symptoms change at work/with hobbies? _____
 Odor of fume exposure? _____
 Day care? Days per week: _____

Environmental History

How long in Central Texas? _____
 House/Apt/Mobile Home _____ How old? _____ Flooring? Carpet/Tile/Other: _____
 Heat: Central/Baseboard _____ Air: Central/Window/Water Cooler _____
 Smokers in the house? _____
 Animals in the house? _____

Family History

Age	Health Status	Cause of Death
Father		
Mother		
Sisters		
Brothers		

Check if your blood relatives have had any of the following:

Disease	Relation
<input type="checkbox"/> Arthritis, Gout	
<input type="checkbox"/> Asthma, Hay Fever	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Chemical Dependency	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Disease, Stroke	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Tuberculosis	

Entire form reviewed with patient by:

1. _____	Date: _____	4. _____	Date: _____
2. _____	Date: _____	5. _____	Date: _____
3. _____	Date: _____	6. _____	Date: _____