Dr Pepel Family Practice **Health History Form Page 1**
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Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Date_____

Patient Name_____Birthdate_____

Chief Complaint_____

History of present illness

Location (where is the pain/problem?)
Quality (Example: color, activity, throbbing…)
Severity (Scale 1-10 with 10=most severe)
Duration (When did it start?)
Timing (Does the problem occur at a specific time?)
Context (Where were you at the onset?)
Associated signs/ symptoms/ problems
Modifying factors (What makes it better or worse?)

Past Medical History

Have you ever had the following? (Circle "yes" or "no", leave blank if uncertain)

Measles	no/yes	Anemia	no/yes	Back trouble	no/yes	Hepatitis	no/yes
Mumps	no/yes	Bladder infection	no/yes	High Blood Pressure	no/yes	Ulcer	no/yes
Chickenpox	no/yes	Epilepsy	no/yes	Low Blood Pressure	no/yes	Kidney Disease	no/yes
Whooping Cough	no/yes	Migraine Headache	no/yes	Hemorrhoids	no/yes	Thyroid Disease	no/yes
Scarlet Fever	no/yes	Tuberculosis	no/yes	Date of last chest X-ray	_____		
Diphtheria	no/yes	Diabetes	no/yes	Asthma	no/yes	Any other disease	no/yes
Smallpox	no/yes	Cancer	no/yes	Hives or Eczema	no/yes	(Please list):	
Pneumonia	no/ye	Polio	no/yes	AIDS or HIV+	no/yes		
Rheumatic fever	no/yes	Glaucoma	no/yes	Infectious Mono	no/yes		
Heart disease	no/yes	Hernia	no/yes	Bronchitis	no/yes		
Arthritis	no/yes	Mitral Valve Prolapse	no/yes	Venereal disease	no/yes		
Stroke	no/yes	Bleeding tendency	no/yes	Blood or Plasma transfusion----------			no/yes

Previous Hospitalizations, Surgeries, Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription) _____
_____
_____

Patient Social History

Marital Status	Single	Married	Separated	Divorced	Widowed
Use of alcohol	Never	Rarely	Moderate	Daily	
Use of tobacco	Never	Previously, but quit		Current packs/ day	
Use of drugs	Never	Type/Frequency			
Excessive exposure at home or work to	Fumes	Dust	Solvents	Noise	Air-borne Particles

Health History Form Page 2

Family Medical History Age Diseases If Deceased, Cause of Death

Father_____
Mother_____
Siblings _____
Children_____

Review of systems. Please indicate any personal history below:

Constitutional Symptoms		**Genitourinary**		**Psychiatric**	
Good general health lately	no/yes	Frequent urination	no/yes	Memory loss	no/yes
Recent weight change	no/yes	Burning/ painful urination	no/yes	Nervousness	no/yes
Fever	no/yes	Blood in urine	no/yes	Depression	no/yes
Fatigue	no/yes	Change in force of strain	no/yes	Insomnia	no/yes
Headache	no/yes	Incontinence/ dribbling	no/yes	Suicidal thoughts	no/yes
Eyes		Kidney stone	no/yes	Violent/ unusual thoughts	no/yes
Eye disease or injury	no/yes	Sexual difficulty	no/yes	**Endocrine**	
Wear glasses/contact lenses	no/yes	Male-testicle pain	no/yes	Glandular/hormone problem	no/yes
Blurred or double vision	no/yes	Female-pain with periods	no/yes	Excessive thirst/urination	no/yes
Ears/Nose/Mouth/Throat		Female-irregular periods	no/yes	Heat/cold intolerance	no/yes
Hearing loss or ringing	no/yes	Female-vaginal discharge	no/yes	Skin becoming dryer	no/yes
Earaches or drainage	no/yes	Female # of pregnancies		Change in hat or glove size	no/yes
Chronic sinusitis or rhinitis	no/yes	Female # of miscarriage		**Hematologic/ Lymphatic**	
Nose bleeds	no/yes	Female-date of last PAP		Slow to heal after cuts	no/yes
Mouth sores	no/yes	**Musculoskeletal**		Bleeding/bruising tendency	no/yes
Bleeding gums	no/yes	Joint pain	no/yes	Anemia	no/yes
Bad breath or bad taste	no/yes	Joint stiffness	no/yes	Phlebitis	no/yes
Sore throat or voice change	no/yes	Joint swelling	no/yes	Past transfusion	no/yes
Swollen glands in neck	no/yes	Weakness of muscles	no/yes	Enlarged glands	no/yes
Cardiovascular		Weakness of joints	no/yes	**Allergic/ Immunologic**	
Heart trouble	no/yes	Muscle pain or cramps	no/yes	History of skin reaction or other adverse	
Chest pain or angina pectoris	no/yes	Back pain	no/yes	reaction to:	
Palpitation	no/yes	Cold extremities	no/yes	Penicillin/ other antibiotics	no/yes
Shortness of breath	no/yes	Difficulty in walking	no/yes	Morphine, Demerol/ Narcotics	no/yes
Swelling of feet, hands…	no/yes	**Integumentary/ Skin/ Breast**		Novocain/ Anesthetics	no/yes
Respiratory		Rash or itching	no/yes	Aspirin/ pain remedies	no/yes
Cough/Throat clearing	no/yes	Change in skin color	no/yes	Tetanus antitoxin/ serums	no/yes
Spitting up blood	no/yes	Change in hair or nails	no/yes	Iodine, merthiolate, antiseptics	no/yes
Shortness of breath	no/yes	Varicose veins	no/yes	Other drugs/ medication_____	
Wheezing	no/yes	Breast pain	no/yes	_____	
Gastrointestinal		Breast lump	no/yes		
Loss of appetite	no/yes	Breast discharge	no/yes	Food allergies_____	
Change in bowel movements	no/yes	**Neurological**		_____	
Nausea/vomiting	no/yes	Frequent headaches	no/yes	Environmental allergies_____	
Frequent diarrhea	no/yes	Dizzy/ light headed	no/yes	_____	
Painful bowel movements	no/yes	Convulsions/ seizures	no/yes		
Constipation	no/yes	Numbness/ tingling	no/yes		
Rectal bleeding/blood in stool	no/yes	Tremors	no/yes		
Abdominal pain	no/yes	Paralysis	no/yes		
		Head injury	no/yes		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient/ Guardian _____Date_____