Wellness Tree Community Clinic

Patient Health History - CONFIDENTIAL

Patient Name: _____ Date:_____

Date of Birth:_____ Age:_____ Date of last physical exam: _____

What is the reason for your visit: _____

_____

Symptoms

Mark (**X**) symptoms you currently have or have had in the past year.

General

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Genito-Urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Cardiovascular

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

Eye/Ear/Nose/Throat

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problmes
- ☐ Vision - flashes
- ☐ Vision - halos

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Men Only

- ☐ Sore on penis
- ☐ Penis discharge
- ☐ Erectile difficulties
- ☐ Breast lump
- ☐ Lump in testicles
- ☐ Other

Women Only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period:

_____

Date of last mammogram:

_____

Date of last Pap Smear:

_____

Are you pregnant?_____

Number of children_____

Number of pregnancies_____

Conditions

Mark (**X**) conditions you currently have or have had in the past year.

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostrate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsilitits
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Vernereal Disease

Immunizations

Date of last Tetanus shot_____ Date of last Flu shot_____ Date of last Pneumovax_____

Medications (List your current medications: name, strength, frequency)	**Allergies**

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Patient and Family Health History

Patient Name: _____ Date of Birth:_____ Date:_____

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Mark (**X**) if your blood relatives have had the following:		
⬇	Disease	Relationship to You
☐	Arthritis, Gout	
☐	Asthma, Hay Fever	
☐	Cancer / Type	
☐	Chemical Dependency	
☐	Diabetes	
☐	Heart Disease, Strokes	
☐	High Blood Pressure	
☐	Kidney Disease	
☐	Tuberculosis	
☐	Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization & Outcome

Have you ever had a blood transfusion? ☐ YES ☐ NO

Serious Illness/Injuries

Serious Illness/Injuries	Date	Outcome

If yes, give approximate date(s):_____

Health Habits

Y / N Sunscreen? **Y / N** Seatbelts?

Mark (**X**) which you use and how much you use:

☐	Caffeine	
☐	Tobacco	
☐	Street Drugs	
☐	Alcohol	
☐	Exercise	
☐	Other	

Pregnancies

Year of Birth	Sex of Birth	Complications if Any

Occupational

Mark (**X**) if you are exposed to:	Occupation:
☐ Stress ☐ Hazardous Substances ☐ Heavy Lifting ☐ Other	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my medical provider if I, or my minor child, ever have a change in health.

_____ _____

Signature of patient, Parent, Guardian or Personal Representative Date

_____ _____

Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient