MIDDLESEX FAMILY PRACTICE, P.C.
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HEALTH HISTORY (Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical Examination_____

What is your reason for visit?_____

SYMPTOMS Check (√) symptoms you currently have or have had in the past year.

GENERAL

□ Chills
□ Depression
□ Fainting
□ Fever
□ Forgetfulness
□ Headache
□ Loss of sleep
□ Loss of weight
□ Nervousness
□ Numbness
□ Sweats

MUSCLE/Joint/Bone Pain, weakness, numbness in:

□ Arms □ Hips
□ Back □ Legs
□ Feet □ Neck
□ Hands □ Shoulders

GENITO-URINARY

□ Blood urine
□ Frequent urination
□ Lack of bladder control
□ Painful urination

GASTRIONTESTINAL

□ 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 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 Problems
□ Vision – Flashes
□ Vision – Halos

SKIN

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

MEN ONLY

□ Breast Lump
□ Erection Difficulty
□ Lump in testicles
□ Penis discharge
□ Sore on penis
□ 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 Pap Smear____
Have you had a mammogram? Yes □ No □
Are you pregnant? Yes □ No □
Number of Children ____

CONDITIONS Check (√) conditions you have or have had in the past.

□ 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
□ Live Disease
□ Measles
□ Migraine Headaches
□ Mononucleosis
□ Multiple Sclerosis
□ Mumps
□ Pacemaker
□ Pneumonia
□ Polio
□ Prostate Problem
□ Psychiatric Care
□ Rheumatic Fever
□ Scarlet Fever
□ Stroke
□ Suicide Attempt
□ Thyroid Problems
□ Tonsillitis
□ Tuberculosis
□ Typhoid Fever
□ Ulcers
□ Vaginal Infections
□ Venereal Disease

List medications you are currently taking.	ALLERGIES To medications or substances

Signature:_____ Date:_____