Castle Rock Family Physicians

HEALTH HISTORY

NAME:_____ DATE OF BIRTH_____/_____/_____

PAST PERSONAL MEDICAL PROBLEMS:_____

_____

PAST PERSONAL SURGERIES:_____

_____

ALLERGIES:_____

CURRENT PERSONAL MEDICINE USE:_____

FAMILY HEALTH HISTORY:

Father is living / dead Age at death:____ Health problems:_____

Mother is living / dead Age at death:____ Health problems:_____

Health problems of brothers / sisters:_____

Grandparents medical problems: _____

PERSONAL HISTORY:

Yes	No		Yes	No		Yes	No	
___	___	Acne concerns	___	___	Earaches; frequent	___	___	Shortness of breath
___	___	Alcohol use	___	___	Eczema	___	___	Sinus trouble; frequent
___	___	Allergies; Food	___	___	Emphysema / COPD	___	___	Skin cancer
___	___	Allergies; Seasonal	___	___	Erectile dysfunction [ED]	___	___	Skin; fragile
___	___	Anemia/Blood disorder	___	___	Exercise regularly	___	___	Sleep troubles
___	___	Angina / chest pains	___	___	Eye injury / problems	___	___	Snoring
___	___	Asthma as child / adult	___	___	Fainting	___	___	Sore throat; frequent
___	___	Arthritis	___	___	Faith is part of my life	___	___	Stomach problems
___	___	Back surgeries	___	___	Finger/Toenail changes	___	___	Stool changes
___	___	Bladder infections; freq	___	___	Hair loss	___	___	Tattoos
___	___	Blood in urine	___	___	Headaches; frequent	___	___	Thyroid problems
___	___	Blood in stool	___	___	Hepatitis/jaundice	___	___	Tired / Weak
___	___	Blood pressure; High	___	___	History of heart attack	___	___	Tobacco; use regularly
___	___	Bowel problems	___	___	Heart beat; irregular	___	___	Transfusions pre 1992
___	___	Breast lump	___	___	Heartburn / reflux	___	___	Ulcers; history of
___	___	Bronchitis; frequent	___	___	Height loss	___	___	Urinate; awaken to
___	___	Broken bones; history of	___	___	Hemorrhoids	___	___	Urinary dribbling
___	___	Calcium Supplements	___	___	Herbal/Natural remedies	___	___	Urination;frequent
___	___	Cancer; Personal history	___	___	Hernia	___	___	Vision changes
___	___	Cholesterol; High	___	___	Leg edema / swelling	___	___	Weight gain past year
___	___	Condoms; Use Regularly	___	___	Moles; unusual/changing	___	___	Weight loss past year
___	___	Constipation/diarrhea	___	___	Muscle aches			
___	___	Ever lost consciousness	___	___	Neck larger than 17 inches	Misc:		
___	___	Cough; Frequent	___	___	Osteoporosis			
___	___	Cough with exercise	___	___	Pain with intercourse	___	___	I wear my seat belt
___	___	Depression	___	___	Pneumonia; frequent	___	___	I use a helmet
___	___	Diabetes / Sugar	___	___	Psychiatric problems	___	___	I wear sun screen
___	___	Drug use, recreational, ever in my life	___	___	Rash; current			
			___	___	Rectal pain / problems			
			___	___	Safe; I feel safe at home			
			___	___	Scrotal Masses			
			___	___	Seizures / epilepsy			
			___	___	Sexual Problems			

Personal Health Concerns:_____

I generally consider myself to be in what state of health: excellent good fair poor horrible

Last TB test _____ Last cholesterol check_____ Last glaucoma check_____ Last colonoscopy _____

Last hearing test_____ Last flu vaccine_____ Last tetanus shot_____ Pneumonia shot Y / N _____

Last Bone Density test _____

Men: Last rectal exam_____ Last PSA blood test _____ Monthly testicular self exam Y / N

Women: Last PAP test: _____ Last Mammogram _____ Monthly self breast exam Y / N

Date_____ _____