

HOXIE MEDICAL CLINIC
HEALTHCARE...FROM THE HEART
 HEALTH HISTORY (Confidential)



Name: _____ Today's Date: _____

Age: _____ Birth date: _____ 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	GASTROINTESTINAL	CARDIOVASCULAR	EYE, EAR, NOSE, THROAT
<input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<input type="checkbox"/> Appetite Poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel Changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive Hunger <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Stomach Pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Rapid Heart Beat <input type="checkbox"/> Swelling of Ankles <input type="checkbox"/> Varicose Veins SKIN <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in Moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Crossed Eyes <input type="checkbox"/> Hard to Swallow <input type="checkbox"/> Double Vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Hay Fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of Hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Vision – Flashes <input type="checkbox"/> Vision – Halos
MUSCLE/JOINT/BONE Pain, weakness, or numbness in: <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Neck <input type="checkbox"/> Feet <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	GENITO-URINARY <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Lack of Bladder Control <input type="checkbox"/> Painful Urination	WOMEN ONLY: <input type="checkbox"/> Have you ever had any menstrual issues? <input type="checkbox"/> Are you pregnant?	

CONDITIONS Check conditions you have or have had in the past year

<input type="checkbox"/> AIDS	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Chemical	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Anemia	<input type="checkbox"/> Dependency	<input type="checkbox"/> Hernia	<input type="checkbox"/> Mumps	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Herpes	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Polio	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Goiter	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Scarlet Fever	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Miscarriage		

