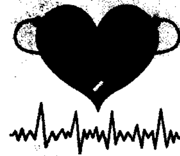
HOXIE MEDICAL CLINIC
HEALTHCARE...FROM THE HEART
HEALTH HISTORY Confidential)



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

_ Chills
_ Depression
_ Dizziness
_ Fainting
_ Forgetfulness
_ Headache
_ Loss of Sleep
_ Loss of Weight
_ Nervousness
_ Numbness
_ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, or numbness in:

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

GASTROINTESTINAL

_ Appetite Poor
_ Bloating
_ Bowel Changes
_ Constipation
_ Diarrhea
_ Excessive Hunger
_ Excessive Thirst
_ Gas
_ Hemorrhoids
_ Indigestion
_ Nausea
_ Rectal Bleeding
_ Stomach Pain
_ Vomiting
_ Vomiting Blood

GENITO-URINARY

_ Blood in Urine
_ Frequent Urination
_ Lack of Bladder Control
_ Painful Urination

CARDIOVASCULAR

_ Chest Pain
_ High Blood Pressure
_ Irregular Heart Beat
_ Low Blood Pressure
_ Poor Circulation
_ Rapid Heart Beat
_ Swelling of Ankles
_ Varicose Veins

SKIN

_ Bruise easily
_ Hives
_ Itching
_ Change in Moles
_ Rash
_ Scars
_ Sore that won't heal

WOMEN ONLY:

_ Have you ever had any menstrual issues?

_ Are you pregnant?

EYE,EAR, NOSE,THROAT

_ Bleeding Gums
_ Blurred Vision
_ Crossed Eyes
_ Hard to Swallow
_ Double Vision
_ Earache
_ Ear Discharge
_ Hay Fever
_ Hoarseness
_ Loss of Hearing
_ Nosebleeds
_ Persistent Cough
_ Ringing in Ears
_ Sinus Problems
_ Vision – Flashes
_ Vision – Halos

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

_ AIDS
_ Alcoholism
_ Anemia
_ Anorexia
_ Appendicitis
_ Arthritis
_ Asthma
_ Bleeding Disorders
_ Breast Lump
_ Bronchitis
_ 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
_ Prostate Problem
_ Psychiatric Care
_ Rheumatic Fever
_ Scarlet Fever
_Stroke
_ Suicide Attempt
_ Thyroid Problems
_ Tonsillitis
_ Tuberculosis
_ Typhoid Fever
_ Ulcers
_ Vaginal Infections
_ Venereal Disease

MEDICATIONS List medications you are currently taking.	**ALLERGIES** To medications.
Pharmacy Name: Phone:	

FAMILY HISTORY Fill in heath information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check Box if your blood relatives had any of the following: Disease		Relationship to you
Father						Asthma, Hay Fever	
Mother						Other Allergies	
Brothers						Arthritis, Gout	
						Cancer	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

HOSPITALIZATIONS Year	Hospital	Reason for Hospitalization & Outcome

HEALTH HABITS check which substances you use & describe how much you use:

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS
Check if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

IMMUNIZATIONS Date of last Flu vaccine

Date of last Tetanus/Diphtheria vaccine

Date of Pneumonia vaccine

Have you ever had a blood transfusion? _ Yes _ No
If yes, please give approximate dates: ____________

Your occupation:

SERIOUS ILLNESS / INJURIES	**DATE**	**OUTCOME**

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor of any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____________________ Date ____________________