

UNIVERSAL PERSONAL HEALTH HISTORY FORM

Name _____ Date Filled Out _____

Primary Care Physician _____

Current Pharmacy _____ Town _____ Telephone# _____

Please list the medication (s), dosage amount, and how many times a day you take each prescription

	<u>Medication Name</u>	<u>Dosage</u>	<u>Times Per Day</u>
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____
6	_____	_____	_____
7	_____	_____	_____
8	_____	_____	_____
9	_____	_____	_____
10	_____	_____	_____
11	_____	_____	_____
12	_____	_____	_____
13	_____	_____	_____
14	_____	_____	_____
15	_____	_____	_____
16	_____	_____	_____
17	_____	_____	_____
18	_____	_____	_____
19	_____	_____	_____
20	_____	_____	_____

Do you have allergies to any medication? If yes, please list them.

List any other allergies to food, latex, pollen, dust, etc?

Please list all your known medical diagnoses:

Childhood _____

Adulthood _____

List Surgeries

Do you have any problems with anesthesia? _____

Recent Hospitalizations _____

Serious Injuries _____

Diseases in Blood Relatives:

Father _____

Mother _____

Brother _____

Sister _____

Grandmother _____

Grandfather _____

Aunt _____

Uncle _____

If you smoke, how many packs per day? _____ How many years? _____

Other tobacco use _____

If you drink alcohol, what do you drink and how often?

Marital Status: SINGLE___ MARRIED___ WIDOWED___ DIVORCED___

General			Musculoskeletal		
Fever	Y	N	Joint Pain	Y	N
Fatigue	Y	N	Neck Pain	Y	N
Weight loss	Y	N	Back Pain	Y	N
Other _____			Other _____		
Eyes			Neurological		
Blurred vision	Y	N	Tremors	Y	N
Double vision	Y	N	Dizzy spells	Y	N
Pain	Y	N	Numbness/Tingling	Y	N
Other _____			Other _____		
Ears, Nose, and Throat			Psychological		
Pain (where? _____)	Y	N	Depressed	Y	N
Sinus trouble	Y	N	Anxious	Y	N
Trouble swallowing	Y	N	Other _____		
Other _____					
Heart			Hematological/ Lymphatic		
Chest pain	Y	N	Lymph node pain/ swelling	Y	N
Palpitations	Y	N	Bleeding problem	Y	N
Other _____			Other _____		
Lungs			Endocrine		
Wheezing	Y	N	Heat/cold intolerance	Y	N
Cough	Y	N	Excessive thirst	Y	N
Shortness of breath	Y	N	Tired/ Sluggish	Y	N
Other _____			Other _____		
Gastrointestinal			Skin		
Abdominal Pain	Y	N	Rash	Y	N
Heartburn	Y	N	Itch	Y	N
Ulcer	Y	N	Hives	Y	N
Reflux	Y	N	Skin infection	Y	N
Bloody or Tarry Stools	Y	N	Keloid or hypertrophic scar	Y	N
Other _____			Other _____	Y	N
Genitourinary			Allergy/ Immunology		
Discharge	Y	N	Hay fever	Y	N
Pain on Urination	Y	N	Immune deficiency	Y	N
Frequency	Y	N	Arthritis	Y	N
Other _____			Other _____		