Blackhawk MEDICAL GROUP …a division of BASS Medical Group

Health History (All information is strictly confidential)

Name _____ Today's Date_____
Age _____ Date of Birth: _____ Date of last physical exam_____
Reason for today's visit? _____

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

GENERAL
- ☐Chills
- ☐Depression
- ☐Dizziness
- ☐Fainting
- ☐Fever
- ☐Forgetfulness
- ☐Headache
- ☐Loss of sleep
- ☐Loss of weight
- ☐Nervousness
- ☐Numbness
- ☐Sweats

MUSCLE/JOINT/BONE
Pain/weakness/numbness in:
- ☐Arms
- ☐Back
- ☐Feet
- ☐Hands
- ☐Hips
- ☐Legs
- ☐Neck
- ☐Shoulders

GENITO-URINARY
- ☐Blood in urine
- ☐Frequent urination
- ☐Lack of bladder control
- ☐Painful urination

GASTROINTESTINAL
- ☐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 of 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 difficulties
- ☐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_____

Date of last mammogram? _____

Are you pregnant? _____

Number of Children _____

_____
Note:

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
- ☐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

Health History Continued	**Page Two**	**NAME:**	
MEDICATIONS List medications you are currently taking		**ALLERGIES** To medications or substances	

Pharmacy Name: _____ Pharm Location: _____
Pharmacy Phone: _____ Pharmacy FAX: _____

FAMILY HISTORY Fill in health information about your family.

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

HOSPITALIZATIONS Year	History	Reason for Hospitalization and Outcome	**PREGNANCY HISTORY Year of Birth**	**Sex of Birth**	**Complications, if any**

HEALTH HABITS Check which substances you use and describe how much you use.			**OCCUPATIONAL CONCERNS** Check if your work exposes you to the following:	
	Caffeine			Stress
	Tobacco			Hazardous Substances
	Drugs			Heavy Lifting
	Other			Other

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

Your occupation:

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