Northwest Wellness Center

HEALTH HISTORY

Confidential

Patient Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Date of Last Physical Exam: _____

What is your 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 ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulder

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: _____

Have you had a mammogram? ☐yes ☐no

Are you pregnant? ☐yes ☐no

Number of children: _____

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

MEDICATIONS List Medications you are currently taking.

ALLERGIES To medications or substances.

Pharmacy Name: Phone:

(Vers.M2SSS04)

909 E. Palatine Road ▪ Palatine, Illinois 60074 ▪ 847-776-0606 ▪ fax 847-776-1864

Patient Name: **Date of Birth:**

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Cause at Death	Check if your blood relatives 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	Hospital	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.

☐	Caffeine	
☐	Tobacco	
☐	Street Drugs	
☐	Other	
☐		
☐		

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates:

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS

Check if your work exposes you to the following:

☐	Stress
☐	Hazardous Substances
☐	Heavy Lifting
☐	Other

Your occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

_____ _____

Reviewed By Date