KINESIS Healthcare

Name _____
Date _____
File # _____

CONFIDENTIAL HEALTH HISTORY

Y = Yes (currently or within the past year) **P** = Past Leave Blank if it does not apply.

GENERAL

1 ____ Fever/ Chills
2 ____ Sweating/ Night Sweats
3 ____ Disturbed Sleep
4 ____ Fatigue/ Weakness
5 ____ Memory Loss
6 ____ Weight Loss or Gain
7 ____ Diabetes
8 ____ Allergies (food, medicine, airborne…)
9 ____ Bleeding Disorders
10 ____ Anemia
11 ____ Cancer or Tumor
12 ____ HIV/ AIDS Exposure or Risk Factors
13 ____ Eating Disorder
14 ____ Mood Swings
15 ____ Anxiety/ Depression
16 ____ Phobia
17 ____ Psychiatric Treatment
18 _____ Date of Last Physical
19 ____ Childhood Vaccinations
20 ____ Other Vaccinations

GASTROINTESTINAL

1 ____ Change in Appetite: Poor or Excessive
2 ____ Difficulty Digesting Fatty Foods
3 ____ Difficulty or Painful Swallowing
4 ____ Hernia Type: _____
5 ____ Heartburn/ GERD
6 ____ Ulcers
7 ____ Belching or Gas/ Bloating
8 ____ Frequent Nausea
9 ____ Vomiting or Vomiting Blood
10 ____ Diarrhea
11 ____ Constipation
12 ____ Undigested Food in Stool
13 ____ Hemorrhoids
14 ____ Black or Bloody Stool
15 ____ Mucus in stool
16 ____ Anal Itching/ Discomfort
17 ____ Appendicitis
18 ____ Liver Problems (Jaundice Hepatitis Cirrhosis Other)
19 ____ Gall Bladder Problem
20 ____ Other

EYE, EAR, NOSE, THROAT

1 ____ Poor Vision/ Glasses
2 ____ Astigmatism
3 ____ Pain in Eye(s)
4 ____ Floaters
5 ____Eye Discharge
6 ____ Excess Tearing or Dryness
7 ____ Glaucoma
8 ____ Cataracts
9 ____ Eye Surgery
10 ____ Postnasal Drip
11 ____ Sinus Trouble
12 ____ Nosebleeds
13 ____ Bleeding Gums
14 ____ Sores
15 ____ Loss of or Abnormal Taste
16 ____ Hoarseness
17 ____ Ringing in Ears
18 ____ Deafness/ Hearing Problem
19 ____ Dental Problems
20 ____ Root Canal(s)
21 ____ Tonsillectomy
22 ____ Bruxism: Grinding Teeth
23 ____ TMJ/ Jaw problems
24 ____ Other

ENDOCRINE

1 ____ Heat/ Cold Intolerance
2 ____ Goiter
3 ____ Thyroid Condition (Hypothyroid Hyperthyroid Other)
4 ____ Adrenal Condition (Cushing's Addison's Other)

CARDIOVASCULAR

1 ____ Irregular Heart Beat/ Palpitations
2 ____ Murmur
3 ____ High Blood Pressure Medicated? Y / N
4 ____ Atherosclerosis
5 ____ Pain Over Heart
6 ____ Heart Attack
7 ____ Stroke
8 ____ Ankle Swelling
9 ____ Varicose Veins
10 ____ Aortic Aneurysm
11 ____ Deep Leg Pain
12 ____ Thrombophlebitis
13 ____ Cold Hands/ Feet
14 ____ Other (Congenital…)

PULMONARY

1 ____ Seasonal Allergies
2 ____ Hay Fever
3 ____ Hives
4 ____ Wheezing/ Asthma
5 ____ Shortness of Breath
6 ____ Difficulty Breathing in Bed
7 ____ Chronic Cough
8 ____ Spitting/ Coughing Phlegm
9 ____ Spitting/ Coughing Blood
10 ____ Pneumonia
11 ____ Tuberculosis
12 ____ COPD: Bronchitis or Emphysema?
13 ____ Pneumothorax
14 ____ Other

GENITOURINARY

1 ____ Frequent Urination
2 ____ Painful Urination
3 ____ Blood in Urine
4 ____ Kidney Stones
5 ____ Kidney Disease
6 ____ Urinary Tract Infection
7 ____ Inability to Control Urination
8 ____ Difficulty Starting Urine Flow
9 ____ Get Up _____ Times Per Night to Urinate
10 ____ Sexually Transmitted Disease/ Infection
Syphilis Gonorrhea
Chlamydia Genital Warts Other

SKIN, HAIR, NAILS

1 ____ Itching
2 ____ Psoriasis
3 ____ Change in Mole(s)
4 ____ Rashes
5 ____ Change in Hair or Nails
6 ____ Other

NEUROLOGIC

1 ____ Epilepsy or Seizures
2 ____ Twitching
3 ____ Tremors
4 ____ Migraines
5 ____ Headaches
6 ____ Weakness
7 ____ Paralysis
8 ____ Tingling
9 ____ Numbness
10 ____ Parkinson's
11 ____ Multiple Sclerosis
12 ____ Alzheimer's
13 ____ Schizophrenia
14 ____ Fainting
15 ____ Dizziness/ Vertigo
16 ____ Bell's Palsy
17 ____ Other

MUSCULOSKELETAL

1 ____ Generalized Stiffness
2 ____ Neck Stiffness/ Pain
3 ____ Pain Between Shoulders
4 ____ Low Back Pain
5 ____ Muscle Aches/ Soreness
6 ____ Arthritis
Type: _____
7 ____ Swollen or Painful Joints
8 ____ Scoliosis/ Spinal Curvature
9 ____ Herniated Disc
10 ____ Sciatica
11 ____ Congenital Spinal / Osseous Anomalies
12 ____ Other

FEMALE REPRODUCTIVE

Age Menses Began ____
Average # of Days ____
Length of Cycle ____
Date Last Period Began ____
Date of Last PAP/Gyne Exam _____
Any Abnormal PAP Tests or Mammograms? Y / N
Are you currently pregnant? Y / N

1 ____ Spotting/ Bleeding Between Periods
2 ____ Excessive Flow
3 ____ Painful Menses
4 ____ Bloating or Cramping with Menses
5 ____ Irregular Cycles
6 ____ Pain During Intercourse
7 ____ Menopause Age Began ____
____ Hot Flashes ____ Chills
8 ____ Hormone Replacement Therapy
9 ____ Oral Birth Control
10 ____ Intrauterine Device
11 ____ Other Forms of Contraception
12 ____ Breast Lumps
13 ____ Breast Pain or Tenderness
14 ____ Nipple Discharge
15 ____ Miscarriage
16 ____ Live Births
17 ____ Vaginal Burning/ Itching
18 ____ Vaginal Discharge
19 ____ Fertility Treatment

MALE

1 ____ Hernias
2 ____ Testicular Swelling/ Pain
3 ____ Prostate Problems
4 ____ Erectile Dysfunction
5 ____ Other

Date of Last Digital Rectal or PSA Exam _____

ACCIDENTS/TRAUMA

1 ____ Motor Vehicle Accidents
2 ____ Fractures/ Dislocations
3 ____ Concussions
4 ____ Other

HABITS

1 ____ Smoking ____ packs/day for ____ months/yrs
2 ____ Drinking
3 ____ Recreational Drug Use
4 ____ Other

CHILDHOOD DISEASES

1 ____ Mumps
2 ____ Measles
3 ____ Chicken Pox
4 ____ Rubella
5 ____ Polio
6 ____ Rheumatic Fever
7 ____ Scarlet Fever
8 ____ Whooping Cough

FAMILY HISTORY

1 ____ Type I Diabetes
2 ____ Type II Diabetes
3 ____ Thyroid Disease
4 ____ Heart Disease
5 ____ High Blood Pressure
6 ____ Cancer
7 ____ Kidney Disease
8 ____ Muscle, Bone, or Nerve Disease
9 ____ Tuberculosis
10 ____ Other

HOSPITALIZATIONS

____ Please List Dates and Reasons:

SURGERIES

____ Please List Dates and Reasons:

MEDICATIONS

____ Please List ALL Current Prescription & Non-Prescription Medications, Dosage, and Reason

VITAMINS, HERBS, SUPPLEMENTS

____ Please List What You are Currently Taking

NUTRITIONAL STATUS

How many meals do you eat each day? _____
Amount of water consumed daily _____
Amount of coffee, soda, & black tea consumed daily _____
How often do you eat processed or fast foods? _____
Any current diet restrictions or regimen? Y / N

When do you eat your largest meal? _____
Do you feel drowsy after meals? Y / N
What kinds of foods or beverages do you crave? _____
Do you have any food sensitivities? _____
Are you satisfied with your current diet? Y / N

EXERCISE

How often do you exercise? _____
What kind of exercise do you do? _____
Are you involved in competition? Y / N

OCCUPATION: _____

Number of Hours Worked Per Week: _____
Do you regularly come in contact with harmful chemicals or substances? Y / N
Specify _____

I certify that the information I have supplied is accurate to the best of my knowledge.

Name _____

Signature _____

Date _____