EAST CAROLINA MEDICAL ASSOCIATES - Confidential Health History

Name: ___________________________, ______________________ ________ Date: ________________________
LAST FIRST INITIAL

Soc.Sec.#: ____________________ _____ Age: __________ Date of last physical exam: ____________________

What is the reason for your visit today? ____

SYMPTOMS

GENERAL
- ☐ Chills
- ☐ Fever
- ☐ Loss of sleep
- ☐ Loss of weight

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Diarrhea
- ☐ Constipation
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Hemorrhoids
- ☐ Excessive gas

MENTAL HEALTH
- ☐ Depression
- ☐ Nervousness
- ☐ Anxiety
- ☐ Forgetfulness

SKIN
- ☐ Hives
- ☐ Rash
- ☐ Easy Bruising
- ☐ Itching
- ☐ Change in moles
- ☐ Sore will not heal
- ☐ Scar
- ☐ Pigmentation
- ☐ Blemishes

EYE/EAR/NOSE/THROAT
- ☐ Hay fever
- ☐ Blurred vision
- ☐ Double vision
- ☐ Vision flashes
- ☐ Vision halos
- ☐ Sinus problem
- ☐ Loss of hearing ☐ RT ☐ LF
- ☐ Ringing in ears ☐ RT ☐ LF
- ☐ Ear Discharge ☐ RT ☐ LF
- ☐ Earache ☐ RT ☐ LF
- ☐ Nose Bleed
- ☐ Difficult with swallowing
- ☐ Bleeding gums
- ☐ Hoarseness

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart beats
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Leg or Ankle swelling
- ☐ Varicose vein

NERVOUS SYSTEM
- ☐ Dizziness
- ☐ Faint
- ☐ Headaches
- ☐ Numbness
- ☐ Lightheadedness
- ☐ Loss of consciousness

LUNGS
- ☐ Wheezing
- ☐ Persistent coughing
- ☐ Congestion
- ☐ Snoring
- ☐ Apnea

ENDOCRINE SYSTEM
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Excessive fluid intake
- ☐ Excessive sweating

GENITOURINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Flank pain ☐ RT ☐ LF

MUSCLE/JOINT/BONE (Pain/Weakness/Numbness)
- ☐ Arm ☐ RT ☐ LF
- ☐ Shoulder ☐ RT ☐ LF
- ☐ Elbow ☐ RT ☐ LF
- ☐ Wrist ☐ RT ☐ LF
- ☐ Hand ☐ RT ☐ LF
- ☐ Finger ☐ RT ☐ LF
- ☐ Hip ☐ RT ☐ LF
- ☐ Knee ☐ RT ☐ LF
- ☐ Ankle ☐ RT ☐ LF
- ☐ Foot ☐ RT ☐ LF
- ☐ Back ☐ Upper ☐Lower
- ☐ Neck

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Name: ___________________________, ______________________ _______
LAST FIRST INITIAL

MEN ONLY:

☐ Lump in testicles ☐ Penis discharge ☐ Sore on penis ☐ Erectile difficulties

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WOMEN ONLY:

☐ Abnormal pap smear ☐ Breast lump ☐ Vaginal discharge
☐ Bleeding between periods ☐ Extreme menstrual pain ☐ Hot flashes
☐ Painful intercourse ☐ Nipple discharge

DATE OF LAST:

Menstrual Period: ____________________ Pap smear: ____________________ Mammogram: ___________________

ARE YOU PREGNANT? ☐ Yes ☐ No Number of children: ______

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ALLERGIES: ____

VACCINATION HISTORY:

FLU: ☐ Yes ☐ No **PNEUMOVAX**: ☐ Yes ☐ No **TD BOOSTER**: ☐ Yes ☐ No

CONDITIONS:

	Aids		Chemical Dependency		High Cholesterol		Prostrate problem
	Alcoholism		Chicken Pox		HIV Positive		Psychiatric Care
	Anemia		Diabetes		Kidney Disease		Rheumatic Fever
	Anorexia		Emphysema		Liver Disease		Scarlet Fever
	Appendicitis		Epilepsy		Measles		Stroke
	Arthritis		Glaucoma		Migraine Headaches		Suicide Attempt
	Asthma		Goiter		Miscarriage		Thyroid Problems
	Bleeding Disorder		Gout		Mononucleosis		Tonsillitis
	Breast Lump		Hypertension		Multiple Sclerosis		Tuberculosis
	Bronchitis		Heart Disease		Mumps		Typhoid Fever
	Bulimia		Hepatitis		Pacemaker		Ulcers
	Cancer		Hernia		Pneumonia		Vaginal Infections
	Cataracts		Herpes		Pollo		Venereal Disease

SURGICAL HISTORY:

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SOCIAL HISTORY:

Smoking: ☐ Yes ☐ No If yes, how many per day? _____ How long? _____
Alcohol: ☐ Yes ☐ No
Illicit drugs: ☐ Yes ☐ No