JMD Family Practice

Health History Update

Patient Name	Date of Birth	Today's Date

Current Mailing Address	Contact Telephone #

In order to provide you with effective medical care, we need to obtain some basic information about your past and present health. We also need to ask about your lifestyle because it affects your physical and emotional wellbeing.

The questions on the next two pages cover the topics we will discuss. Please answer them to the best of your ability.

Special Information

Please use the space below to tell me about your health, family and social life. What has been important to you in the past, what is going on in your life now, and your hopes for the future. Include any important changes that have occurred:

HEENT

During the past year, have you:	No	Yes
1. Had frequent headaches?	☐	☐
2. Felt dizzy, fainted or had blackouts?	☐	☐
3. Fallen?	☐	☐
4. Had seizures or convulsions?	☐	☐
5. Noticed any lumps on your body or swollen glands?	☐	☐
6. Had eye trouble?	☐	☐
7. Had difficulty hearing?	☐	☐
8. Had trouble with your ears?	☐	☐
9. Had dental or mouth problems?	☐	☐
10. Do you wear dentures?	☐	☐
11. Suffered from nose bleeds?	☐	☐
12. Suffered from allergies or hay fever?	☐	☐
13. Noticed any hoarseness in your voice?	☐	☐

Respiratory/Cardiovascular

	No	Yes
14. Been wheezing or been short of breath?	☐	☐
15. Been coughing frequently?	☐	☐
16. Sweated more than usual or had "night sweats"?	☐	☐
17. Had a racing heart or palpitations?	☐	☐
18. Had tightness or pains in your chest?	☐	☐
19. Had swollen feet or ankles?	☐	☐

GI /GU

	No	Yes
20. Heartburn or indigestion?	☐	☐
21. Abdominal discomfort or pain?	☐	☐
22. Bouts of nausea or vomiting?	☐	☐
23. Difficulty swallowing?	☐	☐
24. Pains in your rectum?	☐	☐
25. Bowel movements that were bloody or tarry?	☐	☐
26. Any change in your bowel habits?	☐	☐
27. Frequent urination during the day or at night?	☐	☐
28. Uncomfortable or difficult urination?	☐	☐
29. Have you ever had a colonoscopy?	☐	☐

If yes, when – Month_____ Day_____ Year_____

Male Reproductive

For Men Only: During the past year, have you:	No	Yes
30. Had a drip or discharge from your penis?	☐	☐
31. Noticed lumps or swelling in your testicles?	☐	☐
32. Had difficulty getting an erection?	☐	☐
33. Decrease in your urinary stream?	☐	☐

Female Reproductive

For Women Only:	No	Yes
34. When was your last menstrual period? Month_____ Day_____ Year_____		
35. If you are past menopause, have you had vaginal bleeding? (If you are past your menopause, please skip to Q. 35)	☐	☐
36. Have there been any changes to your periods?	☐	☐
37. Have you noticed bleeding between your periods?	☐	☐
38. Do you have discomfort during intercourse?	☐	☐
39. Do you bleed from your vagina after intercourse?	☐	☐
40. Do you have any vaginal itching, burning or discharge?	☐	☐
41. Discomfort or pain in your pelvis?	☐	☐
42. Problems with your breasts?	☐	☐
43. When was your last Pap test? Month _____ Day_____ Year_____		
44. Have you ever had an abnormal Pap test?	☐	☐
45. When was your last Mammogram? Month_____ Day_____ Year_____		
46. Have you ever had an abnormal Mammogram?	☐	☐

Skin and Extremities

During the past year, have you:	No	Yes
47. Had any skin problems or noticed any changes in your skin? If yes, please describe: _____ _____	☐	☐
48. Had aching muscles or joints?	☐	☐
49. Had leg cramps?	☐	☐