



Interim Health History

Date: _____

Name: _____

DOB: _____

During the past year, have you:

Had a poor appetite?	Y	N	Do you have problems swallowing?	Y	N
Had less energy than usual?	Y	N	Do you have frequent nausea?	Y	N
Experienced night sweats?	Y	N	Do you have too much heartburn?	Y	N
Gained more than 10 pounds?	Y	N	Do you vomit frequently?	Y	N
Lost more than 10 pounds?	Y	N	Have you vomited blood?	Y	N
Been unusually weak?	Y	N	Is urination painful?	Y	N
Is your skin too dry?	Y	N	Is your urine ever bloody?	Y	N
Problems with fingernails or toenails?	Y	N	Do you ever leak urine?	Y	N
Does your skin itch too much?	Y	N	Do you have back pain?	Y	N
Do you have any rashes?	Y	N	Do you have joint pain?	Y	N
Do you have any sores?	Y	N	Do you have muscle aches?	Y	N
Is your vision normal?	Y	N	Do you have frequent headaches?	Y	N
Date of last eye exam: _____			Balance or coordination problems?	Y	N
Do you have hearing loss?	Y	N	Numbness or tingling in hands or feet?	Y	N
Do you have ringing in your ears?	Y	N	Do your hands shake?	Y	N
Do you frequently get dizzy?	Y	N	Do you have difficulty concentrating?	Y	N
Does your nose drip?	Y	N	Do you worry too much?	Y	N
Do you have nosebleeds?	Y	N	Are you too nervous?	Y	N
Is your throat frequently sore?	Y	N	Do you have trouble making decisions?	Y	N
Do you have any neck pain?	Y	N	Are you frequently irritable?	Y	N
Do you cough more than normal?	Y	N	Are you having difficulty sleeping?	Y	N
Are you short of breath?	Y	N	Are you intolerant to heat or cold?	Y	N
Do you ever cough up blood?	Y	N	Is your hair dry or brittle?	Y	N
Do you cough up much mucous?	Y	N	Has your interest in sex changed?	Y	N
Do you wheeze?	Y	N	Do you bruise or bleed too easily?	Y	N
Do you have any breast lumps?	Y	N	(Women)		
Do you have any breast pain?	Y	N	Do you have menstrual problems?	Y	N
Do you have any breast discharge?	Y	N	Do you have unusual vaginal discharge?	Y	N
Have you had any worrisome chest pain?	Y	N	Is intercourse painful?	Y	N
Do you have swelling in your ankles?	Y	N	Date of last period: _____		
Do you need to sleep sitting up?	Y	N	(Men)		
Do you have palpitations?	Y	N	Has your urine stream changed?	Y	N
Do you have abdominal pain?	Y	N	Any difficulty starting urination?	Y	N
Have your bowel movements changed?	Y	N	Any dribbling after urination?	Y	N
Do you have constipation?	Y	N	Any sexual dysfunction?	Y	N
Do you have diarrhea/loose stools?	Y	N			
Have you had rectal bleeding?	Y	N	Date of last Td (tetanus) Shot: _____		

Have you taken any new or different medications since you were last here?	Y	N
Have you become allergic to any medications since you were last here?	Y	N
Have you had any new operations or hospitalizations?	Y	N
Have there been any new illnesses among your mother, father, or siblings?	Y	N
Has your lifestyle changed regarding exercise, tobacco, or alcohol usage?	Y	N
Is there anything else you wish to tell us about your health today?		

Thank you for completing your health history form. Please return this form to us so we may enter your data into our records. If you have any questions about how to complete the form, please let us know. Thanks.