

P. COREY JACKSON, M.D.

PATIENT HEALTH HISTORY

Patient Name _____ Date _____

Age _____ Birthdate _____ Date of last physical exam _____

Reason for today's visit _____

Who referred you to our clinic? _____ Relationship _____

Thank you for choosing our office! To help us meet your healthcare needs, please fill out both sides of this form completely in ink. This is a confidential record of your medical history and will be kept in this office. Please understand that filling out this form accurately is necessary for the healthcare staff to perform the healthcare services that your child or you may need, and that it is the patient's responsibility to notify the doctor or healthcare staff of any changes.

SYMPTOMS (PLEASE CIRCLE 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 _____ Shoulders _____

Heart/Circulation

Chest pain
High Blood Pressure
Irregular Heart Beat
Low Blood Pressure
Poor Circulation
Rapid Heart Beat
Swelling of Ankles
Varicose Veins

Stomach/Bowels

Appetite Poor
Bloating
Bowel Changes
Constipation
Diarrhea
Excessive Hunger
Excessive Thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal Bleeding
Stomach Pain
Vomiting
Vomiting Blood
Black or Tarry Stools

Skin

Bruise Easily
Hives
Itching
Change in Moles
Rash
Scars
Sores Won't Heal
Tears easily

Eye/Ears/Nose/Throat

Bleeding Gums
Blurred Vision
Crossed Eyes
Difficulty Swallowing
Double Vision
Earache
Ear Discharge
Hay Fever
Hoarseness
Hearing Loss
Nosebleeds
Persistent Cough
Ears Ringing
Sinus Problems
Vision-Flashes
Vision-Halos
Injury to Eyes

Kidney/Bladder

Blood in urine
Frequent Urination
Lack of Bladder control
Painful Urination

Men Only

Breast Lump
Erection Difficulty
Lump in Testicles
Penis Discharge
Sore on Penis
Other _____

Women Only

Abnormal Pap Smear
Bleeding between Periods
Breast Lump
Severe Menstrual Pain
Hot Flashes
Nipple Discharge
Painful Intercourse
Vaginal Discharge
Other _____
Date of Last Menstrual Period _____

_____ Date of Last Pap Smear _____

_____ Date of Last Mammogram/Result _____

_____ Are you Pregnant? _____

_____ Number of Children _____

PAST MEDICAL CONDITIONS (CIRCLE CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST)

AIDS	Cancer	Heart Disease	Mononucleosis	Suicide Attempt
Alcoholism	Cataracts	Hepatitis	Multiple Sclerosis	Thyroid Problems
Anemia	Chemical Dependency	Hernia	Mumps	Tonsillitis
Anorexia	Chicken Pox	Herpes	Pacemaker	Tuberculosis
Appendicitis	Diabetes	High Cholesterol	Pneumonia	Typhoid Fever
Arthritis	Emphysema	HIV Positive	Polio	Ulcers
Asthma	Epilepsy	Kidney Disease	Prostate Problem	Vaginal Infection
Bleeding Disorders	Glaucoma	Liver Disease	Psychiatric Care	
Breast Lumps	Goiter	Measles	Rheumatic Fever	
Bronchitis	Gonorrhea	Migraine Headaches	Scarlet Fever	
Bulimia	Gout	Miscarriage	Stroke	

FAMILY HISTORY (PLEASE FILL IN INFORMATION ABOUT YOUR FAMILY)

Has any blood relative had any of the following:

		Relationship	Present Age or Age at Death	If living, health (good, fair, poor) If deceased, cause of death
Arthritis, Gout.....no	yes	_____		
Asthma, Hay Fever.....no	yes	_____	Father	_____
Cancer.....no	yes	_____	Mother	_____
Chemical Dependency.....no	yes	_____	Siblings	_____
Diabetes.....no	yes	_____		_____
Heart Disease, Strokes.....no	yes	_____		_____
High Blood Pressure.....no	yes	_____		_____
Other _____		_____	Spouse	_____

Illnesses/Hospitalizations

Please list all serious illnesses, operations and other hospitalizations you have experienced and indicate the year they occurred.

Pregnancy History

Year	M/F	Complications, if any
_____	_____	_____
_____	_____	_____
_____	_____	_____

Occupational Concerns

What is your occupation? _____

Are you exposed to:

Stress.....no yes

Hazardous Substances.....no yes What? _____

Heavy Lifting.....no yes How Much? _____

Other _____

Current Medications

Medication	Strength/mg	Number of Times/Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Accidents/Injuries

Please list all serious accidents or severe injuries and dates they occurred.

Health Habits

Please describe how much of the following you use, if any:

Caffeine _____

Tobacco _____

Drugs _____

Alcohol _____

Allergies

Medication Name	Reaction
_____	_____
_____	_____
_____	_____

Other Allergies: _____

Signature of Patient or Parent/ Guardian of Minor