HORIZONS DIAGNOSTICS, LLC
Patient Health History

Name:________________________ Age:_____ DOB:__________ Date: __________
Occupation:____________________ Education:_____High School _____College Graduate

Personal History:

Illnesses:

Have you ever had: (please circle Y for yes or N for no)

High Blood Pressure	Y	N	Kidney Infection	Y	N
Low Blood Pressure	Y	N	Bladder Infection	Y	N
Heart Disease	Y	N	Cirrhosis	Y	N
Heart Attacks	Y	N	Tuberculosis	Y	N
Blood Clots	Y	N	Cancer	Y	N
Phlebitis	Y	N	Type:_________________________		
Stroke	Y	N	Goiter	Y	N
Diabetes	Y	N	Epilepsy	Y	N
Gout	Y	N	Nervous Breakdown	Y	N
Sinusitis	Y	N	Gonorrhea	Y	N
Asthma	Y	N	Syphilis	Y	N
Emphysema	Y	N	Polio	Y	N
Bronchitis	Y	N	Anemia	Y	N
Stomach Ulcer	Y	N	Mumps	Y	N
Duodenal Ulcer	Y	N	Rheumatic Fever	Y	N
Colitis	Y	N	German Measles	Y	N
Gall Bladder Disease	Y	N	Chicken Pox	Y	N
Kidney Stones	Y	N	Any Other Disease:______________		

Injuries:

Concussion or Head Injury	Y	N	Ever Been Knocked		
Car Accident Injury	Y	N	Unconscious?	Y	N

Allergies: are you allergic to:

Penicillin	Y	N	Sulfa	Y	N
Aspirin	Y	N	Codeine	Y	N
Latex	Y	N	Any other known allergies:________________________________		

Surgical History:

Please list all operations and date of surgery:____
____

Systems:

Do you have or have you ever had <u>long standing:</u>

cough	Y	N
sputum (phlegm)	Y	N
chest pain	Y	N
ankle swelling	Y	N
palpitation	Y	N
angina	Y	N
cramps in legs	Y	N
increase in appetite	Y	N
decrease in appetite	Y	N
nausea	Y	N
vomiting	Y	N

Alcoholic Beverages:
___never ___rarely ___moderate ___heavy

Use of Tobacco:
___ packs ___per day

Medications taken regularly:
____
____
____
____

Names of treating Physicians:
____
____

Systems (cont):

diarrhea	Y	N
constipation	Y	N
abdominal pain	Y	N
gas pain	Y	N
heartburn	Y	N
blood in stool	Y	N
headache	Y	N
dizziness	Y	N
fainting spells	Y	N
seizures	Y	N
muscle weakness	Y	N
numbness/tingling	Y	N
impaired hearing	Y	N
do you wear glasses	Y	N
do you wear contacts	Y	N
frequent urination	Y	N
burning urination	Y	N
difficulty urinating	Y	N
Foul smelling urine	Y	N
Color change in urine	Y	N
do you bleed easily	Y	N
do you bruise easily	Y	N
fever	Y	N
weight loss	Y	N
weight gain	Y	N
lack of energy	Y	N
do you sleep well	Y	N

Women Only:

vaginal bleeding	Y	N
vaginal discharge	Y	N
vaginal itching	Y	N

Women Only:

Do you take birth control pills?

___ yes ___ no

Number of years:___

Menstrual History:

age at onset: ___

regular: ___yes ___no

cycle: ___days (from start to start)

usual duration: ___days

heavy___ medium___ light___

pain or cramps: ___yes ___no

date of last period: __________

date of last pap smear: __________

Pregnancies:

how many pregnancies: ____

any complications with pregnancy

____yes ____no

Menopause

age and year in which periods stopped:

___age _____year

Family History:

Have any of your family members been diagnosed with the following conditions?

Diabetes Y N Cancer Y N Stroke Y N

High Blood Pressure Y N Heart Disease Y N

(Please circle alive or deceased)

Is your mother: alive deceased Current Age? ___ (or age at death ___)

Is your father: alive deceased Current Age? ___ (or age at death ___)

How many TOTAL brothers and sisters? _________

How many are still living? ________

Patient or Guardian Signature____________________________________Date____________