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 yes or 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 long standing:

cough	Y	N		Alcoholic Beverages:	
sputum (phlegm)	Y	N		___never ___rarely ___moderate ___heavy	
chest pain	Y	N		Use of Tobacco:	
ankle swelling	Y	N		___ packs ___per day	
palpitation	Y	N		Medications taken regularly:	
angina	Y	N		_____	
cramps in legs	Y	N		_____	
increase in appetite	Y	N		_____	
decrease in appetite	Y	N		_____	
nausea	Y	N		Names of treating Physicians:	
vomiting	Y	N		_____	
diarrhea	Y	N		_____	
constipation	Y	N		_____	
abdominal pain	Y	N			
gas pain	Y	N			

Systems cont.

heartburn	Y	N		Women Only:	
				Do you take birth control pills?	

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

___ 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

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