Blackhawk MEDICAL GROUP **…a division of BASS Medical Group**

Health History (All information is strictly confidential)

Name _____ Today's Date_____
Age _____ Date of Birth: _____ Date of last physical exam_____
Reason for today's visit? _____

SYMPTOMS Check 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
- ☐Back
- ☐Feet
- ☐Hands
- ☐Hips
- ☐Legs
- ☐Neck
- ☐Shoulders

GENITO-URINARY
- ☐Blood in urine
- ☐Frequent urination
- ☐Lack of bladder control
- ☐Painful urination

GASTROINTESTINAL
- ☐Appetite poor
- ☐Bloating
- ☐Bowel changes
- ☐Constipation
- ☐Diarrhea
- ☐Excessive hunger
- ☐Excessive thirst
- ☐Gas
- ☐Hemorrhoids
- ☐Indigestion
- ☐Nausea
- ☐Rectal bleeding
- ☐Stomach pain
- ☐Vomiting
- ☐Vomiting blood

CARDIOVASCULAR
- ☐Chest pain
- ☐High blood pressure
- ☐Irregular heart beat
- ☐Low blood pressure
- ☐Poor circulation
- ☐Rapid heart beat
- ☐Swelling of ankles
- ☐Varicose veins

EYE, EAR, NOSE, THROAT
- ☐Bleeding gums
- ☐Blurred vision
- ☐Crossed eyes
- ☐Difficulty swallowing
- ☐Double vision
- ☐Earache
- ☐Ear discharge
- ☐Hay fever
- ☐Hoarseness
- ☐Loss of hearing
- ☐Nosebleeds
- ☐Persistent cough
- ☐Ringing in ears
- ☐Sinus problems
- ☐Vision- Flashes
- ☐Vision- Halos

SKIN
- ☐Bruise easily
- ☐Hives
- ☐Itching
- ☐Change in moles
- ☐Rash
- ☐Scars
- ☐Sore that won't heal

MEN only
- ☐Breast lump
- ☐Erection difficulties
- ☐Lump in testicles
- ☐Penis discharge
- ☐Sore on penis
- ☐Other

WOMEN only
- ☐Abnormal Pap Smear
- ☐Bleeding between periods
- ☐Breast lump
- ☐Extreme 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? _____

Are you pregnant? _____

Number of Children _____

_____
Note:

CONDITIONS Check conditions you have or have had in the past.

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

Health History Continued	**Page Two**	**NAME:**	
MEDICATIONS List current **medications with the dosage**		**ALLERGIES** To medications or substances	

FAMILY HISTORY Fill in health information about your family.

Relation	**Age**	**State of Health**	**Age at Death**	**Cause of Death**	**Check if your first line relatives have had any of the following:**		
						Disease	**Relationship to you**
Mother						Arthritis, Gout	
Father						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease	
Sisters						High Blood Pressure	
						Kidney Disease	
						Stroke	
						Tuberculosis	
						Other	

HOSPITALIZATIONS: Medical Year	**Reason for Hospitalization and Outcome**		**PREGNANCY HISTORY** Year of Birth	Sex of Birth	Complications, if any
HOSPITALIZATIONS:Surgical Year	**Type of Surgery**	**Outcome**			
SERIOUS ILLNESSES	**Date**	**Outcome**			

HEALTH HABITS Check which substances you use and **describe how much you use each week.**				**OCCUPATIONAL CONCERNS** Check if your work exposes you to the following:	
YES	**NO**	Alcohol			Stress
YES	**NO**	Caffeine			Hazardous Substances
YES	**NO**	Drugs			Heavy Lifting
YES	**NO**	Tobacco			Other
YES	**NO**	Other			
Have you ever had a blood transfusion? Yes or NO If yes, please give approximate dates:_____				**Your occupation:**	