ARIA COMMUNITY HEALTH CENTER

PERSONAL HEALTH HISTORY

DATE: / / NAME: DOB: / /

Do you ever have or have you ever had any of the following:		GENITOURINARY	(NEVER) (PAST) (NOW)
		•Blood or pus in urine	( ) ( ) ( )
SKIN	(NEVER) (PAST) (NOW)	•Sexually transmitted disease	( ) ( ) ( )
•Rashes, hives, itching or other	( ) ( ) ( )	(venereal disease)	
skin irritations.		•Been sexually active with	( ) ( ) ( )
EYES, EARS, NOSE ,THROAT	(NEVER) (PAST) (NOW)	anyone who has AIDS or HIV or hepatitis	
•Headaches, dizziness, fainting	( ) ( ) ( )	**NEUROMUSCULAR**	(NEVER) (PAST) (NOW)
•Blurred or impaired vision	( ) ( ) ( )	•Problems with becoming	( ) ( ) ( )
•Hearing loss or ringing in ears	( ) ( ) ( )	tired and/or upset easily	
•Discharge from eyes or ears	( ) ( ) ( )	•Nervous breakdown/depression	( ) ( ) ( )
•Sinus trouble/colds/allergies	( ) ( ) ( )	•Poliomyelitis (infantile paralysis)	( ) ( ) ( )
•Asthma or hay fever	( ) ( ) ( )	•Convulsions	( ) ( ) ( )
•Sore throats/hoarseness	( ) ( ) ( )	•Joint and/or muscular pain	( ) ( ) ( )
CARDIOPULMONARY	(NEVER) (PAST) (NOW)	•Back pain or injury/osteomyelitis/	
•Shortness of breath	( ) ( ) ( )	rheumatism	( ) ( ) ( )
•Persistent cough or coughing	( ) ( ) ( )		
up blood or other secretions		**•Are you currently taking any mediations?**	( ) ( ) ( )
•Chills and/or fever	( ) ( ) ( )	if yes, please list them	
•Night sweats	( ) ( ) ( )	1 6	
•Tuberculosis or exposed to TB	( ) ( ) ( )	2 7	
•Scarlet fever or rheumatic fever	( ) ( ) ( )	3 8	
•Chest pain	( ) ( ) ( )	4 9	
•Heart palpitations or rapid heart-	( ) ( ) ( )	5 10	
beat or pulse		•Have you ever had or been treated for	( ) ( ) ( )
•High blood pressure	( ) ( ) ( )	cancer or any tumors?	
•Swelling of hands and/or feet	( ) ( ) ( )	•Are you anemic or have you ever had to	( ) ( ) ( )
GASTROINTESTINAL	(NEVER) (PAST) (NOW)	take iron medication?	
•Heartburn or indigestion	( ) ( ) ( )	•Do you use tobacco?	( ) ( ) ( )
•Nausea and/or vomiting	( ) ( ) ( )	if yes, what type?**	
•Loss of appetite	( ) ( ) ( )	**_____	
•Belching or gas	( ) ( ) ( )	•Do you use drugs or alcohol? If yes, what?**	( ) ( ) ( )
•Peptic ulcer, gallbladder, or liver	( ) ( ) ( )	** •Drug?	( ) ( ) ( )
disease		** •Alcohol?	( ) ( ) ( )
		WOMEN ONLY	
•Yellow jaundice or hepatitis	( ) ( ) ( )	Last menstrual period:_____	
•Diarrhea or constipation	( ) ( ) ( )	Birth control:_____	
•Dysentery	( ) ( ) ( )	List dates of all operations/surgeries, injuries	
•Rectal bleeding, hemorrhoids	( ) ( ) ( )	and illnesses that required hospitalization:	
(piles)		_____	
•Tarry or clay-colored stools	( ) ( ) ( )	_____	
GLANDS	(NEVER) (PAST) (NOW)	_____	
•Weight gain or loss	( ) ( ) ( )	•Were you ever rejected from the military or for	( ) ( ) ( )
•Diabetes	( ) ( ) ( )	employment?	
•Thyroid or goiter	( ) ( ) ( )	•Were you absent from school/work in the past	( ) ( ) ( )
•Swollen glands	( ) ( ) ( )	10 years because of illness or injury?	
GENITOURINARY	(NEVER) (PAST) (NOW)	•Did you ever file a worker's compensation	( ) ( ) ( )
•Kidney disease or stones or	( ) ( ) ( )	claim?	
Bright's disease		•Did you ever seek psychological or psychiatric	( ) ( ) ( )
•Painful, frequent, or urgent	( ) ( ) ( )	treatment?	
urination		**•Do any of the above involved a worker's**	( ) ( ) ( )
		compensation claim or job injury?	