HealthFit
General Medical History

Name _____ Date of Birth_____ Today's Date_____

Signature:_____ Height_____ Weight_____

Are you currently being treated by another medical professional for any condition?
_____ No, I only go for regular checkups _____Yes, please list below

Condition_____ **Date of Onset** _____

Condition_____ **Date of Onset** _____

Your Past/Current Medical History: (please include date)

☐ Cancer_____ ☐ High Blood Pressure_____ ☐ Thyroid Disease_____
☐ Seizures_____ ☐ Rheumatic Fever_____ ☐ Heart Disease_____
☐ Hepatitis_____ ☐ Venereal Disease_____ ☐ Diabetes_____
☐ HIV_____ ☐ Asthma/Pneumonia_____ ☐ Anemia_____

Other (include chronic illnesses) _____

_____

Surgeries (type of and date)_____

_____

Any recent medical procedures_____

Significant trauma or hospitalizations (auto accidents, falls, concussions, etc.)_____

_____

Are you on antibiotics now or have you used antibiotics in the past 3 months? If so, which antibiotics have you taken?
_____

Do you take any medications or supplements? Please provide detailed list

_____

_____

Are you currently pregnant?_____ What is your due date?_____

Allergies (drugs, chemicals, foods) and your reaction to them _____

_____

Do you have a regular exercise program? ☐ Yes ☐ No Please describe_____

_____

Do you smoke? ☐ Yes ☐ No How many packs per day?_____ How long have you smoked? _____

How much coffee, tea or cola do you drink per day? Coffee_____ Tea_____ Cola_____
How many energy drinks do you drink per day? _____
How much alcohol do you drink per day?_____
Describe any use of drugs for non-medical purposes_____

Are you a Vegan? ☐ Yes ☐ No For how long? _____
Are you a Vegetarian? ☐ Yes ☐ No For how long? _____

Review of Systems

Please check any symptoms you have had in the last three months.

General
- □ Overweight
- □ Underweight
- □ Lack of Energy
- □ Fatigue
- □ Insomnia
- □ Night sweats
- □ Sweat easily
- □ Excessive thirst
- □ Recurrent infections

Skin
- □ Rashes
- □ Itching
- □ Eczema
- □ Pimples
- □ Dry skin / scalp
- □ Moles
- □ Warts
- □ Changes in Skin/hair
- □ Sores on skin/in mouth

Head, Eyes, Nose, Throat
- □Headaches
- □ Dizziness
- □ Poor hearing
- □ Blurry vision
- □ Troubled vision (glasses)
- □ Eye pain
- □ Facial Pain
- □ Nose bleeds
- □ Teeth problems

Cardiovascular
- □ High blood pressure
- □ Low blood pressure
- □ Chest pain
- □ Palpitations
- □ Abnormal rhythm (arterial fibrillation or flutter)
- □ Failed stress test
- □ Varicose veins
- □ Swelling in arms or legs
- □ Bleeding/clotting problems
- □ Blood clot

Respiratory
- □ Difficulty breathing
- □ Asthma
- □ COPD
- □ Pain with breathing
- □ Shortness of breath
- □ Cough with sputum
- □ Dry cough
- □ Seasonal/environmental allergies
- □ Snoring

Digestive
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Heartburn
- □ Indigestion
- □ Bloating or Excessive gas
- □ Liver problems
- □ Bloody or dark stool
- □ Pain or cramping
- □ Gallstones

Genito-Urinary
- □ Pain with urination
- □ Urgency with urination
- □ Frequent urination
- □ Blood in urine
- □ Decreased urine flow
- □ Unable to hold urine
- □ incontinence - ever
- □ Kidney stones
- □ Impotency
- □ Changes in sex drive
- □ Frequent nighttime urination

Gynecological
- □ Irregular periods
- □ Painful periods
- □ Heavy periods
- □ Missed periods
- □ PMS/PMDD
- □ Vaginal discharge
- □ Fibroids
- □ Endometriosis
- □ Infertility
- □ Breast lumps
- □ Nipple discharge

Obstetrical
- □ # of pregnancies _____
- □ # of births _____
- □ # of premature births____
- □ Age of 1st menses _____
- □ # days between menses_____
- □ 1st day of last menses_____
- □ Age of menopause_____
- □ Date of last PAP_____
- □ Date of last Mammogram_____

Musculoskeletal
- □ Neck pain
- □ Back pain
- □ Shoulder pain
- □ Elbow, wrist or hand pain
- □ Hip pain
- □ Knee pain
- □ Ankle or foot pain
- □ Joint stiffness or swelling
- □ Weakness
- □ Tender joint
- □ Muscle pain

Neurological
- □ Numbness
- □ Tingling
- □ Loss of strength
- □ Loss of balance
- □ Poor memory
- □ Seizures
- □ Head injury
- □ Nerve damage
- □ Rashes
- □ Rashes

Behavioral
- □ Mood swings
- □ Sadness
- □ Anxiety
- □ Aggressiveness/anger
- □ Panic attacks
- □ Uncontrollable fear
- □ Substance abuse
- □ Vacant
- □ Easily stressed
- □ Inappropriate thoughts
- □ Uncontrollable thoughts