



# Health History

Name \_\_\_\_\_ Ht \_\_\_\_\_

DOB \_\_\_\_\_ Wt \_\_\_\_\_

Medical History: list medical problems that you have been treated for in the past and current problems you are being treated for


### Family Medical History:


### Surgical History:


### Circle all that apply:

- |                         |                          |                      |         |
|-------------------------|--------------------------|----------------------|---------|
| Headache                | Abdominal Pain           | Frequent urination   | Cough   |
| Dizziness               | Difficulty Swallowing    | Difficulty Breathing | Chills  |
| Recent Change in vision | Heat or cold intolerance | Palpitations         | tremors |
| Visual Disturbances     | Unexplained weight loss  | Exercise intolerance |         |
| Hearing Loss            | Chest pain               | Heartburn            |         |
| Decreased Smell         | Diarrhea                 | Nausea               |         |
| Hoarseness              | Shortness of breath      | Vomiting             |         |
|                         | Wheezing                 | Constipation         |         |

### Allergies To Medications:


### Current Medications:

Medication	Dosage	Frequency

Tobacco Use: \_\_\_\_\_ NO \_\_\_\_\_ YES; \_\_\_\_\_ Pack per day for \_\_\_\_\_ years

Alcohol Use: \_\_\_\_\_ NO \_\_\_\_\_ YES; How often \_\_\_\_\_, How much \_\_\_\_\_

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