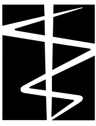

University of North Texas
Health Science Center at Fort Worth
Texas College of Osteopathic Medicine
Department of Family Medicine
Central Clinic

Name____________________ D.O.B.______________

Date____

COMPREHENSIVE HEALTH HISTORY

Allergies:____

____

____

____

Medication Intollerance:______________________________

____

Current Medication:________________________________

____

____

____

____

____

Previous Hospitalizations and Surgeries.

Surgery/Illness	Date	Hospital

Family History

	Age if living	Age at death	State of health
Father			
Mother			
Sibling ☐ M ☐ F			
Sibling ☐ M ☐ F			
Sibling ☐ M ☐ F			

Place an “X” in the box if any blood relative has had:

☐ Tuberculosis	☐ Heart Disease	☐ Diabetes	☐ Hypertension
☐ Arthritis	☐ Stroke	☐ Genetic Dx	☐ Headaches
☐ Depression	☐ Mental Illness	☐ Cancer	☐ Other

Immunizations:

dT__________________________ (date)

Influenza__________________________ (date)

Hepatitis B__________________________ (date)

Pneumococcal__________________________ (date)

Date of last physical ____________________________

Date of last chest x-ray ____________________________

Date of last EKG ____________________________

Date of last dental exam ____________________________

Date of last eye exam ____________________________

Reason for last doctor’s appt. ____________________________

____

Other diagnostic tests ____________________________

PAST HISTORY OF DISEASES

Place an "X" in the appropriate boxes.

Have you had in the past:

Yes No

- ☐ ☐ Measles
- ☐ ☐ Mumps
- ☐ ☐ German Measles
- ☐ ☐ Polio
- ☐ ☐ Chicken Pox
- ☐ ☐ Diptheria
- ☐ ☐ Scarlet Fever
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Infectious Mono
- ☐ ☐ Anemia
- ☐ ☐ Hypothyroid Disease
- ☐ ☐ Hyperthyroid Disease
- ☐ ☐ Pneumonia
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Heart Attack
- ☐ ☐ Diseases of Arteries
- ☐ ☐ Phlebitis
- ☐ ☐ Varicose Veins
- ☐ ☐ Diabetes
- ☐ ☐ Hypertension

Yes No

- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Osteoarthritis
- ☐ ☐ Stroke
- ☐ ☐ Hernia (groin)
- ☐ ☐ Peptic Ulcer Disease
- ☐ ☐ Gallbladder Disease
- ☐ ☐ Diverticulitis
- ☐ ☐ Urinary Track Infection
- ☐ ☐ Kidney Stone
- ☐ ☐ Prostate Disease
- ☐ ☐ Depression
- ☐ ☐ Mental Disorders
- ☐ ☐ Sexually Transmitted Diseases
- ☐ ☐ Hepatitis
- ☐ ☐ Hemorrhoids
- ☐ ☐ HIV
- ☐ ☐ Eczema
- ☐ ☐ Psoriasis
- ☐ ☐ Cancer
- ☐ ☐ Serious Injuries (include fractures)
- ☐ ☐ Other

Explanation of any yes answers ____

____

____

____

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____

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Name____________________ D.O.B.______________

Date____

PAST HISTORY OF SYMPTOMS

Place an "X" in the appropriate boxes.

Have you at any time had:

Yes	No	
Head and Neck		
☐	☐	Decreased hearing
☐	☐	Ringing in ears
☐	☐	Frequent ear infections
☐	☐	Dizzy spells
☐	☐	Failing vision
☐	☐	Double vision
☐	☐	Blurred vision
☐	☐	Eye pain
☐	☐	Repeated eye infections
☐	☐	Recurrent nose bleeds
☐	☐	Dental disease
☐	☐	Sinus trouble
☐	☐	Frequent sore throats
☐	☐	Neck swelling
☐	☐	Hay fever
Respiratory		
☐	☐	Hoarsness
☐	☐	Persistent cough
☐	☐	Blood in spit
☐	☐	Shortness of breath
Cardiovascular		
☐	☐	Chest pain travelling down left arm
☐	☐	Palpitations
☐	☐	Irregular heart beat
☐	☐	Swollen ankles
☐	☐	Fainting spells
☐	☐	Pain in legs when walking
Digestive		
☐	☐	Difficulty swallowing
☐	☐	Indigestion or heartburn
☐	☐	Nausea/vomiting
☐	☐	Change in bowel habit
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Blood in bowel movement
☐	☐	Black bowel movement
☐	☐	Jaundice

Yes	No	
Genitourinary		
☐	☐	Painful urination
☐	☐	Blood in urine
☐	☐	Frequent urination
☐	☐	Night time urinary frequency
☐	☐	Loss of control of urine
☐	☐	Decrease in force of urine stream
☐	☐	Sexual dysfunction
Endocrine		
☐	☐	Chronic fatigue
☐	☐	Weight loss – recent
☐	☐	Bruise easily
☐	☐	Cold extremities
☐	☐	Tremors (shaking of hands)
☐	☐	Convulsions
☐	☐	Muscle weakness
Neurological		
☐	☐	Numbness
☐	☐	Tingling sensations
☐	☐	Headaches
☐	☐	Nervousness
☐	☐	Memory Loss
☐	☐	Moodiness
☐	☐	Difficulty falling asleep
☐	☐	Difficulty staying awake
☐	☐	Increased irritability
Musculoskeletal		
☐	☐	Neck pain
☐	☐	Joint swelling
☐	☐	Low back pain
☐	☐	Foot pain
☐	☐	Stiff joints
Skin		
☐	☐	Rash
☐	☐	Hives
☐	☐	Moles

Explanation of any yes answers ____

____

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____

LIFESTYLE QUESTIONS

Do you or your sexual partner use birth control ☐ Yes ☐ No

If yes, which method ____________________

Do you drink alcohol ☐ Yes ☐ No

Have you every felt you should cut down on your drinking ☐ Yes ☐ No

Have you ever felt guilty about your drinking ☐ Yes ☐ No

Have you ever had an "eye-opener" ☐ Yes ☐ No

Have you ever used recreational drugs ☐ Yes ☐ No

Have you ever smoked ☐ Yes ☐ No

Have you ever used marijuana ☐ Yes ☐ No

Have you ever used snuff or dip ☐ Yes ☐ No

Do you drink caffeine (coffee, tea, soft drinks) ☐ Yes ☐ No

FEMALES

Menstrual History

Last Menstrual Period ____________________ Age at first Menses ____________________

Menses: ☐ Regular ☐ Irregular Length of Menses ____________________

Flow: ☐ Heavy ☐ Moderate ☐ Light

☐ Pain before Menses ☐ Pain during Menses

Last Pap ____________ (Date) Abnormal Pap ____________ (Date) ____________ (Result)

Mammography ____________ (Date)

Do you do self breast exam? ☐ Yes ☐ No

Vaginal Discharge or itching ☐ Yes ☐ No

Painful Sex ☐ Yes ☐ No

No. of pregnancies _____ Abortions _____ Miscarriages _____ Premature births _____ Living children _____

MALES

Do you have

Discharge from penis ☐ Yes ☐ No

Difficulty starting urine ☐ Yes ☐ No

Decrease in force of urine stream ☐ Yes ☐ No

Pain on ejaculation ☐ Yes ☐ No

Impotence ☐ Yes ☐ No

Do you do self testicular exam ☐ Yes ☐ No

____

Signature