Room #__________

INTERIM HEALTH HISTORY

Patient Name: ________________________________ Date of Office Visit: ________________________________

Date of Birth: ________________________________

Have you had any new medical problems since your last office visit?

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Describe any new medical problems:

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Have you had a Pneumovax Vaccine? ( ) Yes ( ) No If Yes, when was your most current?____________________________

Have you had a Flu Vaccine? ( ) Yes ( ) No If Yes, when was your most current?____________________________________

Change in family history since last visit:

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Current or Recent Symptoms:

Constitution:
- ( ) Night sweats or fevers
- ( ) Chills
- ( ) Abnormal sweating
- ( ) Weight loss/gain

Eyes:
- ( ) Visual difficulty

ENTM:
- ( ) Nasal congestion or blockage
- ( ) Nose bleeds
- ( ) Ear pain/infections
- ( ) Mouth sores

Respiratory:
- ( ) Shortness of breath
- ( ) Shortness of breath at night
- ( ) Wheezing
- ( ) Shortness of breath around animals
- ( ) Coughing up blood
- ( ) Cough
- ( ) Phlegm production
- ( ) Shortness of breath that is worse at work

Cardiovascular:
- ( ) Chest pain
- ( ) Heart palpitations
- ( ) Loss of consciousness or passing out
- ( ) Irregular heart beat
- ( ) Pain in legs with walking

Gastrointestinal:
- ( ) Indigestion
- ( ) Diarrhea or constipation
- ( ) Choking
- ( ) Abdominal pain
- ( ) Difficulty swallowing
- ( ) Blood in stools

Genitourinary:
- ( ) Increased urinary frequency at night
- ( ) Difficulty urinating

Musculoskeletal:
- ( ) Joint Pain

Skin:
- ( ) Pain or color change of hands with cold exposure
- ( ) Swelling in legs/feet
- ( ) Skin rash

Neurological:
- ( ) Tremors
- ( ) New weakness or numbness
- ( ) Headaches

Endocrine:
- ( ) Infertility/impotence
- ( ) Sexual problems

Heme/Lymp
- ( ) Bruising/Bleeding
- ( ) New Swollen Lymph Node

Psychological:
- ( ) Depression

I have reviewed: ________________________________

Date: ________________________________