Washington University in St. Louis
SCHOOL OF MEDICINE

COMPREHENSIVE HEALTH HISTORY

PLEASE USE BLUE OR BLACK INK ONLY

Name:_____ Today's Date:_____

Date of Birth:_____ Age:_____ Height:_____ ft _____ in Weight:_____ lbs

Primary Doctor Name and Address:

_____

_____

Preferred Pharmacy (Address/Phone):

_____

_____

PAST MEDICAL HISTORY: ***Check all that apply*** ☐ ***None Apply***

☐ Heart attack	☐ Asthma	☐ Rheumatoid arthritis	☐ Depression
☐ Heart failure	☐ Tuberculosis	☐ Osteoarthritis	☐ ADHD
☐ Abnormal heartbeat	☐ Emphysema	☐ Gout	☐ Seizures
☐ High blood pressure	☐ Thyroid	☐ Osteoporosis	☐ Migraine
☐ Stroke	☐ Stomach ulcers	☐ Cirrhosis	☐ Cerebral palsy
☐ Blood clots in leg	☐ Gastric reflux	☐ Hepatitis (A, B or C)	☐ Downs syndrome
☐ Blood clots in lung	☐ Hiatal hernia	☐ HIV/AIDS	☐ Spina bifida
☐ Poor circulation	☐ Kidney failure	☐ Bleeding disorder	☐ Neurofibromatosis
☐ High cholesterol	☐ Kidney stones	☐ Anemia	☐ MRSA

☐ Neuropathy: ☐ Hands or ☐ Feet

☐ Cancer: _____(type/treatment)

☐ Diabetes: year diagnosed _____

Currently controlled with ☐ insulin ☐ oral medications ☐ diet

☐ Other: _____

_____

PAST SURGICAL HISTORY: ☐ ***No Prior Surgery***

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia? ☐ No ☐ Yes
If YES, have you had any problems related to this? ☐ No ☐ Yes
Please explain any problems related to general anesthesia: _____

_____

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Name:_____ Date of Birth:_____

MEDICATIONS (prescribed and over the counter): ☐ ***I take no medications***

Name of Medication	Dose	Reason

ALLERGIES TO MEDICATIONS: ☐ ***No Allergies***

Name of Medication	Reaction (rash, swelling, stomach upset, etc.)

METAL ALLERGIES: ☐ ***No Allergies*** ☐ Yes_____ (List Metals)

SOCIAL HISTORY:

Work status:

☐ Working ☐ Homemaker ☐ Unemployed ☐ Disabled ☐ On leave ☐ Retired ☐ Student

Occupation_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Children ☐ No ☐ Yes, How Many?_____

Do you live alone?_____ If no, who lives with you?_____

Are you currently smoking?_____ If yes, how many packs a day?_____ For how many years?_____

Have you quit smoking? If so, when did you quit?_____ How many years did you smoke?_____

How many packs a day did you previously smoke?_____Other forms of tobacco?_____

Alcohol Use ☐ Never ☐ Rare ☐ Social ☐ Frequently (more than twice a week)

☐ Alcoholic ☐ Recovering Alcoholic

Illegal Drug Use ☐ Never ☐ In the past ☐ Currently Types of Drugs_____

Name:_____ Date of Birth:_____

FAMILY HISTORY: Check all that apply ☐ None apply

	Father	Mother	Brother	Sister	Son	Daughter	Other(Grandparent, etc) (Specify)_____
Heart Disease							
Arthritis							
Seizure							
Bleeding Problems							
High Blood Pressure							
Stroke							
Gout							
Alcoholism							
Cancer							
Blood Clots							
Kidney Problems							
Diabetes							
Lung Problems							
Mental Illness							
Other _____							

Other Family History:_____

_____

_____

REVIEW OF SYSTEMS: (in the past 30 days have you experienced any of the following?)

☐ Fever	☐ Sleep apnea (snoring)	☐ Nausea
☐ Chills	☐ Hoarseness	☐ Vomiting
☐ Weight loss	☐ Cough	☐ Diarrhea
☐ Weight gain	☐ Trouble swallowing	☐ Constipation
☐ Vision changes	☐ ***Chest pain***	☐ Hemorrhoids
☐ Glasses/Contacts	☐ ***Palpitations***	☐ Stomach pain
☐ Hearing loss	☐ Swollen ankles	☐ Urinary difficulty
☐ Dizziness	☐ ***Shortness of breath***	☐ Anxiety
☐ Ear pain	☐ Seasonal allergies	☐ Hyperactivity
☐ Nosebleeds	☐ Skin rashes	☐ Memory loss
☐ Toothache	☐ Swollen glands	☐ Blackouts
☐ Gum problems	☐ Poor appetite	☐ Headache

☐ ***I have not experienced any of the above symptoms in the last 30 days***

☐ Other:_____

_____

FOR OFFICE USE ONLY

I have read and confirmed the above information with the patient/family:

Physician Signature:_____ Date: _____