P. COREY JACKSON, M.D.

PATIENT HEALTH HISTORY

Patient Name_____ Date_____

Age_____ Birthdate_____ Date of last physical exam_____

Reason for today's visit_____

Who referred you to our clinic?_____ Relationship_____

Thank you for choosing our office! To help us meet your healthcare needs, please fill out both sides of this form completely in ink. This is a confidential record of your medical history and will be kept in this office. Please understand that filling out this form accurately is necessary for the healthcare staff to perform the healthcare services that your child or you may need, and that it is the patient's responsibility to notify the doctor or healthcare staff of any changes.

SYMPTOMS (PLEASE CIRCLE SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR)

General
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of Sleep
Loss of Weight
Nervousness
Numbness
Sweats

Muscle/Joint/Bone
Pain, weakness, numbness in:
Arms
Back
Feet
Hands
Hips
Legs
Neck
Shoulders

Stomach/Bowels
Appetite Poor
Bloating
Bowel Changes
Constipation
Diarrhea
Excessive Hunger
Excessive Thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal Bleeding
Stomach Pain
Vomiting
Vomiting Blood
Black or Tarry Stools

Eye/Ears/Nose/Throat
Bleeding Gums
Blurred Vision
Crossed Eyes
Difficulty Swallowing
Double Vision
Earache
Ear Discharge
Hay Fever
Hoarseness
Hearing Loss
Nosebleeds
Persistent Cough
Ears Ringing
Sinus Problems
Vision-Flashes
Vision-Halos
Injury to Eyes

Men Only
Breast Lump
Erection Difficulty
Lump in Testicles
Penis Discharge
Sore on Penis
Other_____

Women Only
Abnormal Pap Smear
Bleeding between Periods
Breast Lump
Severe Menstrual Pain
Hot Flashes
Nipple Discharge
Painful Intercourse
Vaginal Discharge
Other_____
Date of Last Menstrual Period
_____
Date of Last Pap Smear
_____
Date of Last Mammogram/Result
_____
Are you Pregnant?_____
Number of Children_____

Heart/Circulation
Chest pain
High Blood Pressure
Irregular Heart Beat
Low Blood Pressure
Poor Circulation
Rapid Heart Beat
Swelling of Ankles
Varicose Veins

Skin
Bruise Easily
Hives
Itching
Change in Moles
Rash
Scars
Sores Won't Heal
Tears easily

Kidney/Bladder
Blood in urine
Frequent Urination
Lack of Bladder control
Painful Urination

PAST MEDICAL CONDITIONS (CIRCLE CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST)

AIDS
Alcoholism
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Bleeding Disorders
Breast Lumps
Bronchitis
Bulimia
Cancer
Cataracts
Chemical Dependency
Chicken Pox
Diabetes
Emphysema
Epilepsy
Glaucoma
Goiter
Gonorrhea
Gout
Heart Disease
Hepatitis
Hernia
Herpes
High Cholesterol
HIV Positive
Kidney Disease
Liver Disease
Measles
Migraine Headaches
Miscarriage
Mononeucleosis
Multiple Sclerosis
Mumps
Pacemaker
Pneumonia
Polio
Prostate Problem
Psychiatric Care
Rheumatic Fever
Scarlet Fever
Stroke
Suicide Attempt
Thyroid Problems
Tonsillitis
Tuberculosis
Typhoid Fever
Ulcers
Vaginal Infection

FAMILY HISTORY (PLEASE FILL IN INFORMATION ABOUT YOUR FAMILY)

Has any blood relative had any of the following:

		Relationship
Arthritis, Gout.....no	yes	_____
Asthma, Hay Fever.....no	yes	_____
Cancer.....no	yes	_____
Chemical Dependency.....no	yes	_____
Diabetes.....no	yes	_____
Heart Disease, Strokes.....no	yes	_____
High Blood Pressure.....no	yes	_____
Other_____		_____

Illnesses/Hospitalizations

Please list all serious illnesses, operations and other hospitalizations you have Experienced and indicate the year they occurred.

_____

_____

_____

Pregnancy History

Year M/F Complications, if any

_____

_____

_____

_____

Occupational Concerns

What is your occupation?_____

Are you exposed to:

Stress.....no yes

Hazardous Substances.....no yes What?_____

Heavy Lifting.....no yes How Much?_____

Other_____

Current Medications

Medication Strength/mg Number of Times/Daily

_____

_____

_____

_____

_____

_____

	Present Age or Age at Death	If living, health (good, fair, poor) If deceased, cause of death
Father		
Mother		
Siblings		
Spouse		
Children		

Accidents/Injuries

Please list all serious accidents or severe injuries and dates they occurred.

_____

_____

_____

Health Habits

Please describe how much of the following you use, if any:

Caffeine_____

Tobacco_____

Drugs_____

Alcohol_____

Allergies

Medication Name Reaction

_____

_____

_____

_____

Other Allergies:_____

_____

_____

_____

Signature of Patient or Parent/ Guardian of Minor