

# 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 \_\_\_\_\_ Hips \_\_\_\_\_  
Back \_\_\_\_\_ Legs \_\_\_\_\_  
Feet \_\_\_\_\_ Neck \_\_\_\_\_  
Hands \_\_\_\_\_ Shoulders \_\_\_\_\_

#### Heart/Circulation

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

#### 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

#### Skin

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

#### 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

#### Kidney/Bladder

Blood in urine  
Frequent Urination  
Lack of Bladder control  
Painful Urination

#### 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 \_\_\_\_\_

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

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

**FAMILY HISTORY (PLEASE FILL IN INFORMATION ABOUT YOUR FAMILY)**

Has any blood relative had any of the following:

	Relationship	Present Age or Age at Death	If living, health (good, fair, poor) If deceased, cause of death
Arthritis, Gout.....no	yes _____		
Asthma, Hay Fever.....no	yes _____	Father _____	
Cancer.....no	yes _____	Mother _____	
Chemical Dependency.....no	yes _____	Siblings _____	
Diabetes.....no	yes _____	_____	
Heart Disease, Strokes.....no	yes _____	_____	
High Blood Pressure.....no	yes _____	_____	
Other _____	_____	Spouse _____	

**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
_____		
_____		
_____		
_____		
_____		

**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