

SULTAN H. RAHAMAN, M.D., F.A.A.F.P.

PERSONAL HEALTH HISTORY

Confidential - Patient Please Complete Both Pages

NAME		TODAY'S DATE
AGE	DATE OF BIRTH	DATE OF LAST PHYSICAL EXAMINATION

SYMPTOMS Please circle Now, Past or Never for each symptom.

GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN ONLY
Chills Depression Dizziness Fainting Fever Forgetfulness Headache Loss of Sleep Loss of Weight Nervousness / Anxiety Numbness Sweats	Appetite poor Bowel changes Constipation Diarrhea Difficulty swallowing Excessive hunger Excessive thirst Black Stools Hemorrhoids Indigestion Nausea Rectal Bleeding Stomach pain Vomiting Vomiting Blood	Bleeding gums Blurred vision Crossed eyes Double vision Earache Ear discharge Hay fever Hoarseness Loss of Hearing Nosebleeds Ringing in ears Sinus problems	Breast lump Erection difficulties Lump in testicles Penis discharge Sore on penis Other
MUSCLE / JOINT / BONE	CARDIO / PULMONARY	SKIN	WOMEN ONLY
Pain, weakness, numbness in: Arms Back Feet Hands Hips Legs Neck Shoulders	Chest pain High blood pressure Irregular heart beat Swelling of ankles Varicose veins Shortness of Breath Wheezing Persistent Cough Coughing Blood	Bruise easily Hives Itching Change in moles Rash Sore that won't heal	Heavy Men. Bleeding Irregular Men. Period Abnormal Pap Smear Bleed between periods Breast lump Extreme Men. Pain Hot flashes Nipple discharge Painful intercourse Vaginal discharge Other
GENITO-URINARY			Date of last normal menstrual period _____
Blood in urine Frequent urination Lack of bladder control Painful urination Poor urinary stream			Date of last Pap smear _____
			Date of last Mammogram _____
			Are you Pregnant? _____
			Number of Children _____

DIAGNOSES Please circle Now, Past or Never for each diagnoses.

AIDS Alcoholism Anemia Anorexia Arthritis Asthma Bleeding Disorders Breast Lump Bronchitis Bulimia Cancer if yes, type _____ Cataracts	Chemical Dependency Chicken Pox Diabetes Mellitus Emphysema Epilepsy/Seizures Glaucoma Goiter Gonorrhea Gout Heart Disease Hepatitis Hernia - if yes, type _____ Herpes - if yes, type _____	High Cholesterol HIV positive Kidney Disease Liver Disease Measles Migraine Headaches Miscarriage Mononucleosis Multiple Sclerosis Mumps Pacemaker Pneumonia Polio	Prostate Problem Psychiatric Disorders Rheumatic Fever Scarlet Fever Stroke Suicide Attempt Thyroid Problems Tonsillitis Tuberculosis Typhoid Fever Ulcers - if yes, type _____ Vaginal Infections Venereal Disease
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MEDICATIONS List medications you are currently taking.

ALLERGIES To medications or substances & symptoms experienced

Pharmacy name	Phone No.	
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