CAPSTONE
MEDICAL WELLNESS CENTER

~ Health History Form ~

4807 Jonestown Road, Suite 141, Harrisburg PA 17109

Patient Name:_____

Today's Date:_____ Date Of Birth: _____

Symptoms:

Review of Systems: ("X" all that you have experienced in the past year)

General:
- □ Loss of appetite
- □ Fever
- □ Chills
- □ Sweats
- □ Weight Gain
- □ Weight Loss
- □ Fatigue

Eyes:
- □ Double vision
- □ Discharge/drainage
- □ Flashing lights
- □ Blurry vision
- □ Itching

ENT - Ears, Nose, Throat:
- □ Hearing loss
- □ Ear pain
- □ Ringing in ears
- □ Nasal congestion
- □ Nose bleeds
- □ Post nasal drip
- □ Runny nose
- □ Change in smell
- □ Dental problems
- □ Hoarse voice
- □ Pain / Difficulty swallowing
- □ Sore throat

Cardiovascular:
- □ Chest pain / tightness
- □ Swelling of ankles
- □ Fainting spells
- □ Palpitations
- □ Leg pain with walking / exercise

Respiratory:
- □ Cough
- □ Shortness of breath
- □ Coughing up blood
- □ Wheezing

Gastrointestinal:
- □ Abdominal pain
- □ Belching
- □ Constipation
- □ Diarrhea
- □ Gas/Bloating
- □ Heartburn
- □ Blood in stool
- □ Black or tarry stool
- □ Indigestion
- □ Nausea
- □ Vomiting

Genito-Urinary:
- □ Pain / Burning with urination
- □ Blood in urine
- □ Trouble starting urination
- □ Getting up at night to urinate
- □ Frequent urination
- □ Frequent bladder infections

Musculoskeletal:
- □ Joint pain
- □ Muscle cramping
- □ Muscle aches
- □ Back pain
- □ Neck pain
- □ Joint stiffness / swelling
- □ Muscle weakness

Patient Name:_____

Symptoms (continued):

Skin / Hair / Nails:
- □ Bruising
- □ Dryness
- □ Hives
- □ Itching
- □ Rashes
- □ Abnormal hair growth
- □ Hair loss
- □ Brittle nails
- □ Cracking nails
- □ Pitting nails

Neurologic:
- □ Trouble walking
- □ Difficulty concentrating
- □ Confusion
- □ Dizziness
- □ Headaches
- □ Lightheadedness
- □ Memory loss
- □ Numbness / tingling
- □ Drowsiness
- □ Tremors

Psychiatric:
- □ Agitation
- □ Anxious
- □ Frequent crying
- □ Hallucinations
- □ Insomnia
- □ Loss of interest
- □ Mood changes
- □ Suicidal thoughts
- □ Stress

Endocrinologic:
- □ Hot flashes
- □ Night sweats
- □ Excessive thirst
- □ Excessive urination
- □ Ankle swelling

Hematologic / Lymphatic:
- □ Swollen lymph nodes / glands
- □ Easy / excessive bruising
- □ Easy / excessive bleeding
- □ Tender lymph nodes / glands

Men:
- □ Erection difficulties
- □ Low libido (sex drive)
- □ Lump in testicles
- □ Discharge from penis
- □ Sores on penis
- □ Date of last prostate exam_____

Women:
- □ Irregular periods
- □ Low libido (sex drive)
- □ Lump in breasts
- □ Excessive menstrual bleeding
- □ Excessive menstrual cramping
- □ Nipple discharge
- □ Painful intercourse
- □ Vaginal discharge
- □ Date of last PAP test_____
- □ Date of last mammogram_____

Past Medical History

Patient Name: _____

Please "X" all symptoms/conditions that you currently have or have had in the past year.

- □ Acid Reflux
- □ AIDS / HIV
- □ Alcoholism
- □ Anemia
- □ Anorexia Nervosa
- □ Arthritis
- □ Asthma
- □ Bulimia
- □ Cancer
  Type:_____
- □ Cataracts
- □ Diabetes
- □ Diverticulosis
- □ Drug Abuse
- □ Emphysema
- □ Epilepsy / Seizure Disorder
- □ Glaucoma
- □ Gout
- □ Heart Disease
- □ Hemophilia
- □ Hepatitis
- □ High Cholesterol
- □ High Blood Pressure
- □ Irregular Heart Beat
- □ Kidney Disease
- □ Kidney Stones
- □ Liver Disease
- □ Macular Degeneration
- □ Migraine Headaches
- □ Mononucleosis
- □ Multiple Sclerosis
- □ Peripheral Vascular Disease
- □ Pneumonia
- □ Polio
- □ Prostate Disease
- □ Psychiatric Illness
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Seasonal Allergies
- □ Stomach Ulcers
- □ Stroke
- □ Thyroid Disease
- □ Tuberculosis
- □ Venereal Disease

Serious Accidents / Injuries:

- □ Head injuries / concussions
- □ Broken bones
- □ Gunshot / knife wounds
- □ Lacerations
- □ Motor Vehicle Accidents
- □ Work-related injuries

Past Surgical History: (Please list & date, if remembered)

_____

_____

_____

_____

Patient Name: _____

Blood Transfusions? Yes / No If yes, What year?_____

Family History

Father: Alive / Deceased Age: _____

Medical Conditions: _____

_____

If deceased, cause of death: _____

Mother: Alive / Deceased Age: _____

Medical Conditions: _____

_____

If deceased, cause of death: _____

Number of siblings: _____ Brothers: _____ Sisters: _____

Brothers:

1: Alive / Deceased Age:_____ Medical Conditions:_____
2: Alive / Deceased Age:_____ Medical Conditions:_____
3: Alive / Deceased Age:_____ Medical Conditions:_____
4: Alive / Deceased Age:_____ Medical Conditions:_____
5: Alive / Deceased Age:_____ Medical Conditions:_____

Sisters:

1: Alive / Deceased Age:_____ Medical Conditions:_____
2: Alive / Deceased Age:_____ Medical Conditions:_____
3: Alive / Deceased Age:_____ Medical Conditions:_____
4: Alive / Deceased Age:_____ Medical Conditions:_____
5: Alive / Deceased Age:_____ Medical Conditions:_____

Other Significant Family History: _____

_____

_____

Patient Name:_____

Social History

Status: (Please circle)

Single / Married / Separated / Divorced / Widowed / Significant Other

Occupation: _____

Exposure to Environmental Hazards? Yes / No

If yes, what?_____

Tobacco use? Yes / No

If yes, what? _____

Quantity / Frequency: _____

Alcohol use? Yes / No

If yes, what? _____

Quantity / Frequency: _____

Drug use? Yes / No

If yes, what? _____

Quantity / Frequency: _____

Caffeine use? Yes / No

If yes, what? _____

Quantity / Frequency: _____

Medications / Allergies

Prescription Medications:
(Please list prescription medications you are taking)

_____

_____

_____

_____

_____

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_____

_____

_____

_____

Vitamins/Herbal Supplements:
(Please list all supplements)

_____

_____

_____

_____

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_____

_____

Allergies:
(Please list all allergies)

_____

_____

Preferred Pharmacy:

Local:_____

Mail In:_____

Name of Person completing this form:_____

Signature:_____ Date:_____