HEALTH HISTORY

Emerald Coast Internal Medicine and Geriatrics Date ___/___/___

Patient Name _____

Allergies _____

_____

_____

SYMPTOMS

CHECK ANY SYMPTOMS YOU ARE CURRENTLY HAVING OR HAVE HAD IN THE PAST YEAR

GENERAL

Chills __
Depression __
Dizziness __
Fainting __
Fever __
Forgetfulness __
Loss of sleep __
Headache __
Loss/Gain of weight __
Nervousness __
Numbness __
Sweats __

MUSCLE/BONE/JOINT

Pain, Weakness, Numbness in:

Arms __ Hips __
Back __ Legs __
Feet __ Neck __
Hands __ Shoulders __

URINARY

Blood in urine ___
Frequent urination __
Lack of bladder control __
Painful Urination __
Strong Odor __

GASTROINTESTINAL

Poor appetite __
Bloating __
Bowel changes __
Constipation __
Diarrhea __
Excessive hunger __
Excessive thirst __
Gas __
Hemorrhoids __
Indigestion __
Nausea __
Rectal bleeding __
Stomach pain __
Vomiting __
Vomiting blood __

CARDIOVASCULAR

Chest pain __
Low/High blood pressure __
Palpitations __
Irregular heartbeat __