

HEALTH HISTORY (confidential)

PAIN CENTER OF ORLANDO

225 W. SR 434, Suite 205
Longwood, FL 32750
407.679.3337 FAX: 407.678.7246

Name: _____

Age: _____ Birth Date: ____/____/____ Date of last physical examination: ____/____/____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptom you currently have or have had in the past year:

GENERAL

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

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hamds Shoulders

GENITO-URINARY

- Blood in Urine
- Frequent Urination
- Lack of Bladder Control
- Painful Urination

GASTROINTESTINAL EYE, EAR, NOSE, THROAT

- Appetite Poor
- Bloating
- Bowel Changes
- Constipation
- Excessive Hunger
- Excessive Thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting, Blood
- Bleeding Gums
- Blurred Vision
- Crossed Eyes
- Difficulty Swallowing
- Earache
- Ear Discharge
- Hay Fever
- Hoarseness
- Loss of Hearing
- Nosebleeds
- Persistent Cough
- Ringing in Ears
- Sinus Problems
- Vision - Flashes
- Vision - Halos

CARDIOVASCULAR

- 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
- Sore that won't heal

MEN ONLY

- Breast Lump
- Erection Difficulties
- Lump in Testicles
- Penis Discharge
- Other

WOMEN ONLY

- Abnormal Pap Smear
- Bleeding between periods
- Breast Lump
- Extreme Menstrual Pain
- Hot Flashes
- Nipple Discharge
- Painful Intercourse
- Vaginal Discharge
- Other

Date of last menstrual period: ____/____/____
Date of last Pap Smear: ____/____/____
Have you had a mammogram? yes no
Are you pregnant? yes no not sure
Number of Children: _____

CONDITIONS: Check (✓) conditions you have or have had in the past:

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hemia
- Herpes
- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriages
- Mononucleosis
- 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 Infections
- Venereal Disease

MEDICATIONS List medications you are currently taking:

ALLERGIES to medications or substances:

FAMILY HISTORY Fill in health information about your family (All information is strickly confidential)

Relation	Age	State of Health	Age at of Death	Cause of Death	Check (✓) if, your blood relative had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS **PREGNANCY HISTORY**

Year	Hospital	Reason for Hospitalization and Outcome	NUMBER OF BIRTHS	NUMBER OF BIRTHS	Complications, if any:

		HEALTH HABITS	
		Check (✓) which substance you use and describe how much you use:	
		Caffeine	
		Tobacco	
		Drugs	
		Other	

Have you ever had a blood transfusion? Yes No
 If yes, please give approximate dates: _____

SERIOUS ILLNESS/INJURIES **DATE** **OUTCOME**

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Your Occupation: _____