HEALTH HISTORY — THE WORK CLINIC

1. Fill out information and check box ☒ for "yes" OR leave blank ☐ for "no"

Full Name		**Pregnant**	☐Yes ☐No
Hobbies		**Gender**	☐ Male ☐ Female ☐Other:
Allergies			
Current Medications		**Status**	☐Married ☐Single ☐Other:

Personal Health History

☐High blood pressure
☐Heart disease
☐Head/brain injury
☐Diabetes
☐Cancer (describe):

☐Surgeries (describe):

☐Asthma/lung disease
☐Kidney disease/dialysis
☐Liver disease/cirrhosis
☐Nervous or psychiatric disorder (ex: depression)
☐Other (describe):

Social History

☐Tobacco
☐Alcohol
☐Marijuana
☐Cocaine
☐Heroin

Immediate Family History

If yes, indicate whom (mother, father, sister, etc.)

☐Heart Disease:
☐Diabetes:
☐Alcoholism:
☐Cancer:
☐Nervous or psychiatric disorder (ex: depression):

2. Check box ☒ for "yes" if you have been experiencing these symptoms OR leave blank ☐ for "no":

General
☐Weight loss or gain
☐Fatigue
☐Fever or chills
☐Weakness

Skin
☐Rashes
☐Lumps
☐Itching
☐Dryness

Eyes
☐Vision changes
☐Pain
☐Redness
☐Flashing lights

Blood Disorder
☐Ease of bruising
☐Ease of bleeding
☐Anemia

Head
☐Headache
☐Head injury
☐Vertigo
☐Migraine

Ears
☐Decreased hearing
☐Ringing
☐Pain
☐Ear discharge

Nose
☐Congestion
☐Pain
☐Hay fever
☐Nosebleeds

Neck
☐Lumps
☐Pain
☐Stiffness

Respiratory
☐Cough/phlegm
☐Coughing blood
☐Shortness of breath

Throat
☐Difficulty swallowing
☐Pain
☐Sore throat
☐Hoarseness

Urinary
☐Blood in urine
☐Urgency
☐Burning or pain
☐Incontinence

Vascular
☐Calf pain with walking
☐Leg cramping
☐Varicose veins

Cardiovascular
☐Chest pain or discomfort
☐Murmur
☐Palpitations
☐Surgery

Gastrointestinal
☐Nausea or vomiting
☐Abdominal pain
☐Nausea
☐Heartburn
☐Constipation
☐Diarrhea

Neurological
☐Dizziness
☐Fainting
☐Numbness
☐Hand tremors
☐Tingling hands or feet

Endocrine
☐Heat or cold intolerance
☐Sweating
☐Thirst
☐Frequent urination

Psychiatric
☐Nervousness
☐Anxiety
☐Depression
☐Memory loss

Other (list/describe):

Not Applicable
☐No symptoms at all

3. Please sign and date below:

Signature:___________________________________ **Date:**______________________