Health History Form Infrared Breast Health, Ingrid Edstrom

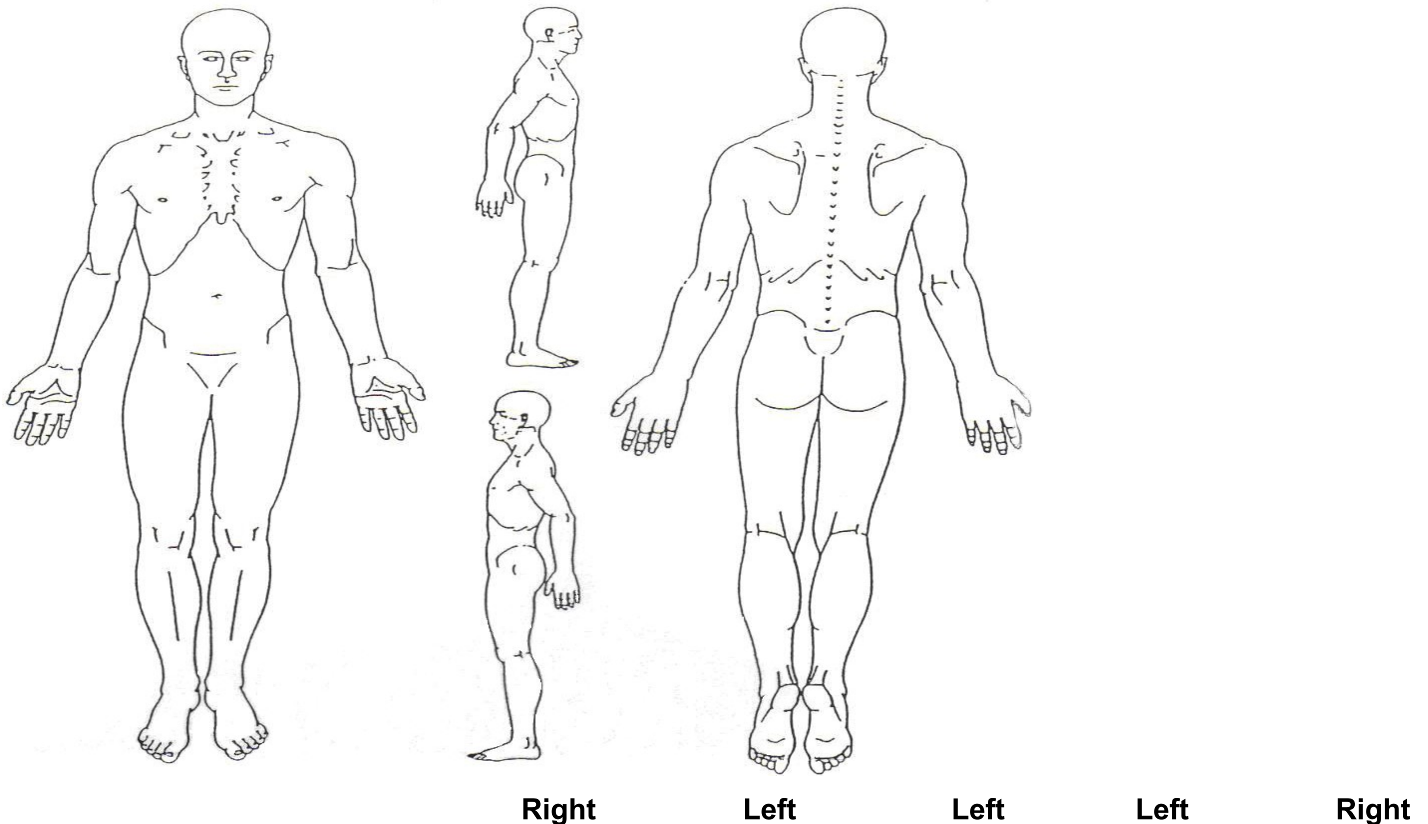
Patient's Name ____ **Date**______________________
Address____ **City**____________________ **State** _____ **Zip**__________
Phone ________________________ **Date of Birth** _________________ **Age**________ **Sex**________
Email________________________________

What are your chief complaints?

1. ____
2. ____
3. ____

Please mark the area and type of pain on the drawing using the following code:

N – Numbness
P – Pain
T – Tingling
A – Ache
S – Soreness
ST – Stiffness



Right **Left** **Left** **Left** **Right**

HABITS

❒ Smoking Packs/Day ____
❒ Drinking Alcohol ____

EXERCISE

❒ None
❒ Moderate

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	❒	❒	❒	❒	❒

❒ Coffee Cups/Day ____ ❒ Daily
Type ___________

Father	❒	❒	❒	❒	❒
Brother	❒	❒	❒	❒	❒
Sister	❒	❒	❒	❒	❒

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

❒ Appendicitis	❒ Anemia	❒ Heart Disease	❒ Arthritis
❒ Pneumonia	❒ Measles	❒ Goiter	❒ Epilepsy
❒ Rheumatic Fever	❒ Mumps	❒ Influenza	❒ Mental Disorder
❒ Polio	❒ Chicken Pox	❒ Pleurisy	❒ Lumbago
❒ Tuberculosis	❒ Diabetes	❒ Alcoholism	❒ Eczema
❒ Whooping Cough	❒ Cancer	❒ Venereal Infection	❒ HIV Positive

OPERATIONS AND PROCEDURES

DATE(S)		DATE(S)		DATE(S)	
______________	Vaccinations	______________	Tubes in Ears	______________	Sinus
______________	Tonsillectomy	______________	Appendectomy	______________	Hernia
______________	Gall Bladder	______________	Female Organs	______________	Thyroid
______________	Back Operation	______________	Rectal Surgery	______________	Stomach
______________	Other	______________	Other	______________	Other

Health History Form Infrared Breast Health, Ingrid Edstrom FNP

Do you have any close family history (father/mother, grandparents, aunts/uncles) of any of the following:

❒ Thyroid problems	❒ Diabetes	❒ Gout	❒ Heart conditions
❒ Ovarian/uterine problems	❒ Liver problems	❒ Gallbladder problems	❒ Stomach problems
❒ Colon problems	❒ Lung conditions	❒ Strokes	❒ Kidney problems

Have you had the flu, a cold, or a respiratory illness (cough) in the last 3 weeks? ❒Yes ❒No

Do you smoke? ❒Yes ❒No When was your last smoke? __________________

Have you experienced a recent trauma? ❒Yes ❒No Date: ________________________

Circle all that apply: a fall / sports injury / car accident / dental work / surgery / *other* ______________

Please answer the following questions in regard to your chief complaints.

COMPLAINT

1: ______________________________ **2:** __________________________ **3:** _________________________

When and how did this problem begin?

❒ suddenly ❒ gradually ❒ suddenly ❒ gradually ❒ suddenly ❒ gradually

________________________________ ____________________________ ___________________________

What makes it better? / Worse?

________________________________ ____________________________ ___________________________

________________________________ ____________________________ ___________________________

Describe your pain/symptoms

❒ achy ❒ sharp ❒ burning ❒ achy ❒ sharp ❒ burning ❒ achy ❒ sharp ❒ burning

❒ sore ❒ tight & stiff ❒ sore ❒ tight & stiff ❒ sore ❒ tight & stiff

❐ numb ❐ pins & needles ❐ numb ❐ pins & needles ❐ numb ❐ pins & needles

How often do you have your symptoms?

❐constantly (100%) ❐frequently (75%) ❐constantly ❐frequently ❐constantly ❐frequently

❐intermittently (50%) ❐occasionally (25%) ❐intermittently ❐occasionally ❐intermittently ❐occasionally

Does the pain radiate anywhere?

❐ down the arms ❐ legs ❐ down the arms ❐ legs ❐ down the arms ❐ legs

Is your pain affected by the time of day?

❐ worse in the morning ❐ evening ❐ worse in morning ❐ evening ❐ worse in morning ❐ evening

❐ better in the morning ❐ evening ❐ better in morning ❐ evening ❐ better in morning ❐ evening

Are you getting:

(Circle) worse **/** better **/** same worse **/** better **/** same worse **/** better **/** same

Health History Form Infrared Breast Health, Ingrid Edstrom FNP

Please Check One: Never – **N**, Previously – **P1**, Presently – **P2**

GENERAL SYMPTOMS

N P1 P2

❐❐❐ Bronchitis
❐❐❐ Chills
❐❐❐ Convulsions
❐❐❐ Dizziness
❐❐❐ Fainting
❐❐❐ Fatigue
❐❐❐ Fever
❐❐❐ Headache
❐❐❐ Loss of sleep
❐❐❐ Loss of weight
❐❐❐ Nervousness
❐❐❐ Neuralgia
❐❐❐ Night sweats
❐❐❐ Numbness/pain in arms/legs/hands
❐❐❐ Wheezing
❐❐❐ Allergy to what: ____________________

GASTRO-INTESTINAL

N P1 P2

❐❐❐ Belching or gas
❐❐❐ Colon trouble
❐❐❐ Constipation
❐❐❐ Diarrhea
❐❐❐ Excessive hunger
❐❐❐ Gall bladder trouble
❐❐❐ Hemorrhoids (Piles)
❐❐❐ Jaundice
❐❐❐ Liver trouble
❐❐❐ Nausea
❐❐❐ Pain over stomach
❐❐❐ Poor appetite
❐❐❐ Poor digestion
❐❐❐ Vomiting
❐❐❐ Vomiting blood

EAR/NOSE/THROAT

N P1 P2

❐❐❐ Asthma
❐❐❐ Crossed Eyes
❐❐❐ Deafness
❐❐❐ Earache
❐❐❐ Ear discharge
❐❐❐ Ear noise
❐❐❐ Enlarged thyroid
❐❐❐ Frequent colds
❐❐❐ Hay fever
❐❐❐ Hoarseness
❐❐❐ Nasal obstruction
❐❐❐ Nose bleeds
❐❐❐ Pain in eyes
❐❐❐ Poor vision
❐❐❐ Sinusitis
❐❐❐ Sore throats
❐❐❐ Tonsillitis

RESPIRATORY

N P1 P2

❐❐❐ Chest pain
❐❐❐ Chronic cough
❐❐❐ Difficulty breathing
❐❐❐ Spitting blood
❐❐❐ Spitting phlegm

GENITO-URINARY

❐❐❐ Bed wetting
❐❐❐ Blood in urine
❐❐❐ Frequent urination
❐❐❐ Inability to control urine
❐❐❐ Kidney infection
❐❐❐ Painful urination
❐❐❐ Prostate trouble

MUSCLES & JOINTS

❐❐❐ Backache
❐❐❐ Foot trouble
❐❐❐ Hernia
❐❐❐ Pain between shoulders
❐❐❐ Painful tailbone

CARDIO-VASCULAR

❐❐❐ High blood pressure
❐❐❐ Low blood pressure
❐❐❐ Pain over heart
❐❐❐ Poor circulation
❐❐❐ Heart trouble

SKIN OR ALLERGIES

❐❐❐ Boils
❐❐❐ Bruise easily
❐❐❐ Dryness
❐❐❐ Eczema
❐❐❐ Hives or allergy

FOR WOMEN ONLY

❐❐❐ Cramps or backaches
❐❐❐ Excessive flow
❐❐❐ Hot flashes
❐❐❐ Irregular cycle

❒❒❒	Stiff neck	❒❒❒	Rapid heart	❒❒❒	Itching	❒❒❒	Miscarriage
❒❒❒	Spinal curvature	❒❒❒	Slow heart	❒❒❒	Sensitive skin	❒❒❒	Painful periods
❒❒❒	Swollen joints	❒❒❒	Stroke	❒❒❒	Skin eruptions	❒❒❒	Vaginal discharge
❒❒❒	Tremors	❒❒❒	Swollen ankles			Y ❒N ❒	Pregnant at this time?
❒❒❒	Twitching	❒❒❒	Varicose veins				
❒❒❒	Weakness						

List any accidents or falls and dates: ❒ Car _______________ ❒ Recreation Vehicle _______________

❒ Sports _______________ ❒ School _______________ ❒ Other _______________

List any broken bones (fractures) or dislocations: ____

Were you ever on crutches? ❒No ❒Yes Why? ____

Have you ever had X-rays taken? ❒No ❒Yes When? _____________

For what ailments were these X-rays taken? ____

Have you ever had any spinal taps or spinal injections? ❒No ❒Yes

Were you ever knocked unconscious? ❒No ❒Yes Have you ever had a lapse of memory? ❒No ❒Yes

Do you suffer from any condition other than that which has been listed previously? _______________________________

Are you currently taking any medication - prescription or over-the-counter? ❒ No ❒ Yes

What: ____

I have completed this 3-page form to the best of my ability.

Signature: ____ Date: ______________________