



# LEAPS, LLC

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## HEALTH HISTORY

(Confidential)

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Date of last physical examination: \_\_\_\_\_ What is your reason for visit? \_\_\_\_\_

**SYMPTOMS** Check (✓) symptoms you currently have or have had in the past year. Check Check (✓✓) for past symptoms.

### General

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

### Muscle / Joint / Bone

Pain, weakness, numbness in:

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

### Genito-Urinary

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

### Gastrointestinal

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

### Cardiovascular

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

### Eye, Ear, Nose, Throat

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes
- Vision – Halos

### 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
- Sore on penis
- 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? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Number of children: \_\_\_\_\_

**CONDITIONS** Check (✓) symptoms you currently have or have had in the past year. Check Check (✓✓) for past symptoms.

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

Hernia

Herpes

High Cholesterol

HIV Positive

Kidney Disease

Liver Disease

Measles

Migraine Headaches

Miscarriage

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



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<b>MEDICATIONS</b> List medications you are currently taking.					<b>ALLERGIES</b> to medications or substances:		
Pharmacy Name:					Phone:		
<b>FAMILY HISTORY</b> Fill in health information about your family.							
Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if your blood relatives 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	
<b>HOSPITALIZATIONS</b>				<b>PREGNANCY HISTORY</b>			
Year	Hospital	Reason for Hospitalization and Outcome		Year of Birth	Gender of Birth	Complications (if any)	
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give approximate dates:				<b>HEALTH HABITS</b> Check (✓) which substances you use and describe how much you use.			
Serious Illness/Injuries		Date	Outcome		Caffeine		
					Tobacco		
					Drugs		
					Other		
<b>OCCUPATIONAL CONCERNS</b> Check (✓) if your work exposes you to the following:							
	Stress			What is your occupation?			
	Hazardous substances						
	Heavy lifting						
	Other:						

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.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_  
Date

All information is strictly confidential