PATIENT HEALTH HISTORY

First Name _____ Last Name _____ Date _____ DOB _____ ☐ Male ☐ Female

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

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Sweats

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASULAR
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Rapid heart beat
- ☐ Swelling of ankles

EYE, EAR, NOSE & THROAT
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nose bleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Rash

WOMEN ONLY
Have you ever had a mammogram? ☐ Y ☐ N
Are you pregnant? ☐ Y ☐ N ☐ Don't know

ILLNESSES OR CONDITIONS Check (✓) illnesses or medical conditions you currently have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chemical dependency
- ☐ DVT
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Gout
- ☐ Heart disease
- ☐ Hepititis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prostate problems
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers

MEDICATIONS List any medications that you are currently taking.

_____

_____

_____

_____

Pharmacy Name/Location _____

ALLERGIES List any allergies to medications or substances.

_____

_____

_____

_____

_____

SURGICAL PROCEDURES

APPROX YEAR	PROCEDURE

FOR OFFICE USE ONLY

I certify that the above information is correct to the best of my knowledge. I will not hold Wake Radiology or any staff member responsible for any errors or omissions that I may have made in the completion of this form.

_____
Print patient name (or guardian)

_____
Patient signature (or guardian) Date