HDC
HOLLYWOOD DIAGNOSTICS CENTER

ADULT HEALTH HISTORY

Patient name:_____ **Date:**_____

Your answers on this form will help your technician get an accurate history of your medical concerns and conditions. If you can't remember specific details, please provide your best guess.
REVIEW OF SYMPTOMS: Please check mark any persistent symptoms you have had in the past few months. Read through every section and check mark "no problems" if none of the symptoms apply to you.

GENITOURINARY
___Leaking urine
___Blood in urine
___Increased urination
___Discharge penis or vagina
___Other
___**No Problems**

INFECTIONS
___MRSA
___Hepatitis
___HIV/AIDS
___Tuberculosis
___Other
___**No problems**

NEUROLOGICAL
___Headaches
___Memory loss
___Fainting/Dizziness
___Numbness/Tingling
___Other
___**No problems**

EARS/NOSE/THROAT
___Nosebleeds/Trouble swallowing
___Frequent sore throat/Hoarseness
___Hearing loss/Ringing in ears
___Other
___**No problems**

RESPIRATORY
___Cough/Wheezing
___Shortness of breath
___Altered breathing
___Other
___**No problems**

GENERAL
___Unexplained weight loss
___Unexplained fatigue
___Fever/Chills
___Other
___**No problems**

GASTROINTESTINAL
___Heartburn/Reflux/Indigestion
___Blood/Bowel movement changes
___Constipation
___Other
___**No problems**

MUSCULOSKELETAL
___Neck pain
___Back pain
___Muscle/Joint pain
___Other
___**No problems**

HEMATOLOGICAL/ LYMPHATIC
___Swollen glands
___Easy bruising
___Other
___**No problems**

CARDIOVASCULAR
___Chest pain/discomfort
___Palpitations
___Other
___**No problems**

ENDOCRINE
___Heat or cold sensitivity
___Other
___**No problems**

SKIN
___Rash/Itching
___Other
___**No problems**

WOMEN ONLY
Are you pregnant? ___**YES** ___**NO** If **NO**, when was your last menstrual cycle?_____
___Problems with menstruation
___Other
___**No problems**