

HEALTH HISTORY

PRACTICE: _____ **DATE:** _____

Name: _____ Age: _____ Birth Date ____/____/____
 Last First MI Sex: Male Female

Highest Grade Completed _____
 Place of Employment _____ How Long? ____ Occupation _____

Single Married Separated Divorced Widowed

Do you have someone available to assist you in time of need? No Yes

If married, spouse's name _____

Children's names and ages _____

Do you live alone? No Yes Do you drive? No Yes

Do you have any special spiritual or religious needs? No Yes

Do you have any special cultural needs? No Yes

Main language that you speak _____

Allergies to Medications, X-ray Dyes, Food, Environmental or Other Substances No Yes

Past Medical History & Review of Systems

Please circle if you have had problems with or are presently complaining of any of the following:

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest pain/discomfort
6. Shortness of Breath
7. Swollen Ankles
8. Palpitations
9. Light Headedness
10. Frequent Urination
11. Rheumatic Fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent Cough
16. T.B.
17. Hay Fever
18. Abdominal Discomfort
19. Indigestion
20. Nausea/Vomiting
21. Constipation
22. Diarrhea
23. Blood in Stool
24. Ulcers
25. Change in Bowel Habits
26. Unexplained Wt Gain/Loss
27. Hemorrhoids
28. Gall Bladder Disease
29. Colitis
30. Hepatitis or Jaundice
31. Thyroid Disease
32. Head or Neck Radiation
33. Headache
34. Kidney Diseases
35. Kidney Stones
36. Difficulty Urinating
37. Arthritis
38. Low Back Problems
39. Skin Diseases
40. Blood Disorders
41. Venereal Diseases
42. Anxiety
43. Depression
44. Anemia
45. Alcohol Abuse
46. Drug Abuse
47. Gout
48. Difficulty eating
49. Stroke
50. Impotency
51. Corrective Eyewear
52. Hearing Difficulty

Any problems not listed above: _____

Level of Independence	Self	Need Assistance
Eating/Meal Preparation		
Toileting		
Walking		
Bathing/Showering		
Dressing		
Household Tasks		

Are you on a special Diet? No Yes Type: _____

Have you had a change in eating habits in past year? No Yes

Do you use any community resources? (i.e. GECAC, Meals on Wheels, Home Health, etc.) No Yes

GYNECOLOGIC AND OBSTETRIC HISTORY

Age of onset of periods: _____ Frequency: _____ Length of Period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Method of birth control _____

Prolonged or abnormal bleeding: No Yes (please describe) _____

Leakage of urine: No Yes (please describe) _____

Pelvic Pain: No Yes _____

Abnormal Discharge: No Yes _____

History of abnormal Pap Smear No Yes _____

PLEASE LIST AND SUPPLY THE DATES OF:

Operations: _____

Hospitalizations other than for surgery: _____

Immunization history-have you had:
 Hepatitis B? No Yes When? _____ Tetanus Immunization? No Yes When? _____
 Flu Immunization? No Yes When? _____
 Other? No Yes When? _____ Pneumovax Immunization? No Yes When? _____

When was your last:
 Pap Smear? _____ Breast Exam? _____ Stool check for blood? _____
 Mammogram? _____ Cholesterol checks? _____ Prostate exam? _____

FAMILY HISTORY Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which Family Members?	Approximate age when diagnosed
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental Disease (anxiety, depression, etc.)	_____	_____
Drug or Alcohol Addiction	_____	_____
Glaucoma	_____	_____
Bleeding Disease	_____	_____
Other: _____	_____	_____

MEDICATIONS (Prescriptions, Over-the Counter, Vitamins, Herbs, etc)

Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____

PREVENTION

Do you wear seatbelts?	No	Yes	If no, why not? _____
Do you wear a bike helmet?	No	Yes	N/A
Do you smoke?	No	Yes	If yes, how many packs/day? _____
Do you drink alcoholic beverages?	No	Yes	If yes, how much/week? _____
Do you drink coffee?	No	Yes	If yes, how many cups/day? _____
Do you drink tea?	No	Yes	If yes, how many cups/day? _____
If there is a gun in your home, is it out of children's reach and unloaded?	No	Yes	N/A
Do you use drugs? (marijuana, cocaine, crack, etc)	No	Yes	If yes, explain _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	No	Yes	
Do you wish to be tested for AIDS?	No	Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	No	Yes	If yes, explain _____
Are you in a relationship in which you have been physically hurt (e.g. slapped, kicked, punched, bruised) by your partner?	No	Yes	
Do you ever feel afraid of your partner?	No	Yes	
Do you have a "living will"?	No	Yes	
Do you have a donor card?	No	Yes	

For Office Use Only:

Initial: _____ date _____ Initial: _____ date _____ Initial: _____ date _____
 Initial: _____ date _____ Initial: _____ date _____ Initial: _____ date _____

