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**Health History Form**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:** \_\_/\_\_/\_\_\_\_

**Age: \_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birth Sex:**  Male  Female

|  |  |
| --- | --- |
| **Gender Identity:**  ¨ Male ¨ Female ¨ Trans: Female to Male ¨ Trans: Male to Female  ¨ Genderqueer ¨ Other: \_\_\_\_\_\_\_\_\_\_\_\_  ¨ Decline to respond | **Sexual Orientation:**   * Straight or heterosexual * Lesbian or gay * Bisexual ¨ Other * Don’t know ¨ Decline to respond |

**Medications** (include supplements, inhalers, birth control and over the counter medications):

|  |  |  |
| --- | --- | --- |
| **Name** | **Strength** | **How often?** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Allergies** (especially medications, specify reaction): Latex Allergy? o Yes o No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History** (please include year):

Appendectomy \_\_\_\_\_\_\_\_\_\_, Gall Bladder Removal \_\_\_\_\_\_\_\_\_\_, Tonsillectomy \_\_\_\_\_\_\_\_\_\_\_,

Hernia Repair \_\_\_\_\_\_\_\_\_\_\_\_\_\_, Hysterectomy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Mastectomy\_\_\_\_\_\_\_\_\_\_, Ovaries\_\_\_\_\_\_\_\_\_\_, Pacemaker\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Heart Stents\_\_\_\_\_\_\_\_\_\_\_\_, C-Section \_\_\_\_\_\_\_\_\_\_,

Tubal Ligation \_\_\_\_\_\_\_\_\_\_, Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Trauma, Hospitalizations, or Serious Illnesses**:

**\*Have you seen other medical providers for routine or specialty care?** o Yes o No

|  |  |  |
| --- | --- | --- |
| 1. Provider Name: | Date: | Seen for: |
| 1. Provider Name: | Date: | Seen for: |
| 1. Provider Name: | Date: | Seen for: |
| 1. Provider Name: | Date: | Seen for: |

\*The care team will ask you to sign a release so we may obtain your records from these providers. Access to these records ensures we can give you the best care possible.

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**Health History Form**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:** \_\_/\_\_/\_\_\_\_

**Health Hazards** (quantity, frequency, and duration of use):

Alcohol: o Yes o No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*Tobacco: o Yes o No If yes, how often? \_\_\_\_\_\_\_\_\_What substance(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*If you do not use tobacco now, have you in the past? o Yes o No | When did you quit? \_\_\_\_\_\_

Marijuana o Yes o No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine: o Yes o No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drugs: o Yes o No If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What substance(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupational Concerns** (Work Exposure): Your Occupation (Current or former): \_\_\_\_\_\_\_\_\_\_\_\_\_

**Job Status:** o Active o Retired

**Safety/Preventative:** Does the Patient use the following?

|  |  |
| --- | --- |
| Seatbelt: o Yes   o No | Smoke Alarms: o Yes   o No |
| Helmets:      o Yes   o No | Are there guns in home?     o Yes   o No |
| Carbon Monoxide Detectors: o Yes   o No | Use of sunscreen o Yes   o No |

|  |  |
| --- | --- |
| **For WOMEN ONLY** | |
| Have you had a recent PAP test?  o Yes/Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_  o No | Have you had a Mammogram?  o Yes/Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_  o No |
| Age of First Menstrual Period: | Menopause Age: |
| Last Menstrual Period: | Number of Pregnancies: |
| Number of Children: |  |

**Miscellaneous Tests:** Have you had any of the following?

Colonoscopy: o Yes/Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_  o No

Dental Exam: o Yes/Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ o No

Eye Exam: o Yes/Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ o No

Recent Hospitalization: o Yes/Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ o No

Recent Labs: o Yes/Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ o No

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_/\_\_\_\_/\_\_\_\_\_**

**Mental Health:**

Over the past 2 weeks, have you been bothered by any of the following?

1. Little interest or pleasure in doing things:

o Not at all       o Several days           o More than half the days  o Nearly everyday

1. Feeling down, depressed, or hopeless:

o Not at all       o Several days           o More than half the days  o Nearly everyday

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Personal Medical History** | | | **Family Medical History** | | |
| **Yes** | **No** | **Medical Problem** | **Yes** | **No** | **Relationship** |
|  |  | Diabetes Mellitus |  |  |  |
|  |  | Hypertension (High Blood Pressure) |  |  |  |
|  |  | Hyperlipidemia (High Cholesterol) |  |  |  |
|  |  | Heart Disease (Angina, Heart Attack) |  |  |  |
|  |  | Congestive Heart Failure |  |  |  |
|  |  | Asthma |  |  |  |
|  |  | Lung Disease (COPD, Emphysema) |  |  |  |
|  |  | Stroke or TIA |  |  |  |
|  |  | Seizure Disorder |  |  |  |
|  |  | Mental Illness (Depression, Anxiety) |  |  |  |
|  |  | Abdominal Problems (Peptic Ulcer, Reflux, Colitis, Pancreatitis, Hepatitis) |  |  |  |
|  |  | Kidney Stones, Renal Failure |  |  |  |
|  |  | Anemia, Sickle Cell, Clotting disorder |  |  |  |
|  |  | Arthritis |  |  |  |
|  |  | Thyroid disease |  |  |  |
|  |  | Eye Disease (Cataracts, Glaucoma) |  |  |  |
|  |  | Skin Disorders (Eczema, Psoriasis) |  |  |  |
|  |  | Environmental or Food Allergies |  |  |  |
|  |  | Cancer or Leukemia  Type: |  |  |  |
|  |  | Alcoholism |  |  |  |
|  |  | Sexually Transmitted Disease, AIDS |  |  |  |
|  |  | Physical or Mental Disabilities |  |  |  |