****

**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  |   |   |   |