Isabella Citizens for Health, Inc.

# Health History Form

**Patient Name:** _____ **DOB:** __/__/____

**Age:** ____ **Today's Date:** ___/___/_____ **Preferred Pharmacy:** _____

**Sex at Birth:** ☐ Male ☐ Female

| **Gender Identity:** | **Sexual Orientation:** |
|---|---|
| ☐ Male ☐ Female ☐ Trans: Female to Male | ☐ Straight or heterosexual |
| ☐ Trans: Male to Female | ☐ Lesbian, gay, or homosexual |
| ☐ Genderqueer ☐ Other: _____ | ☐ Bisexual ☐ Something else |
| ☐ Decline to respond | ☐ 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? ☐ Yes ☐ No

_____

**Past Surgical History** (please include year):
Appendectomy _____, Gall Bladder Removal _____, Tonsillectomy _____,
Hernia Repair _____, Hysterectomy _____, Ovaries_____, C-Section _____,
Tubal Ligation _____, Other: _____

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

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

| | | |
|---|---|---|
| 1. Provider Name: _____ | Date: __/_____ | Seen for: _____ |
| 2. Provider Name: _____ | Date: __/_____ | Seen for: _____ |
| 3. 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.

**Health Hazards** (quantity, frequency and duration of use):
Alcohol: ☐ Yes ☐ No | If yes, how often? _____
**Tobacco: ☐ Yes ☐ No | If yes, how often? _____What substance(s)?_____
**If you do not use tobacco now, have you in the past? ☐ Yes ☐ No | When did you quit? _____
Caffeine: ☐ Yes ☐ No If yes, how often? _____
Drugs: ☐ Yes ☐ No | If yes, how often? _____ What substance(s)? _____

**Occupational Concerns** (Work Exposure): Your Occupation: _____
Stress: _____
Heavy Lifting: _____

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

| | |
|---|---|
| Seatbelt: ☐ Yes ☐ No | Smoke Alarms: ☐ Yes ☐ No |

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| | |
|---|---|
| Helmets: ☐ Yes ☐ No | Are there guns in home? ☐ Yes ☐ No |

| **For WOMEN ONLY** | |
|---|---|
| Have you had a recent PAP test?<br>☐ Yes/Date:___/_____ ☐ No | Have you had a Mammogram?<br>☐ Yes/Date:___/_____ ☐ No |
| Age of First Menstrual Period: _____ | Menopause Age: _____ |

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

| | |
|---|---|
| Colonoscopy: ☐ Yes/Date:___/_____ ☐ No | Skin Cancer Screen: ☐Yes/Date:___/_____☐ No |
| Dental Exam: ☐ Yes/Date:___/_____ ☐ No | Sleep Study: ☐ Yes/Date:___/_____ ☐ No |
| Podiatry Exam: ☐ Yes/Date:___/_____ ☐ No | Eye Exam: ☐ Yes/Date:___/_____ ☐ No |

**Mental Health:** Over the past 2 weeks, have you been bothered by any of the following?

1. Little interest or pleasure in doing things:

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

2. Feeling down, depressed or hopeless:

☐ Not at all ☐ Several days ☐ More than half the days ☐ 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 | | | |
| | | Alcoholism | | | |
| | | Sexually Transmitted Disease, AIDS | | | |
| | | Physical or Mental Disabilities | | | |

NOTES: