

HEALTH HISTORY

Patient Name _____ DOB _____ Date _____

What brings you to the clinic **TODAY**?

List any **ALLERGIES** you have to medications

ALLERGIES	NO	YES
Medication-		
Food-		
Insects_		
Seasonal-		
X-ray dye		
Latex		
Other		

List any **PRESCRIPTION MEDICATIONS** you take and dose:

Do you take any over – the - counter medications? _____

Last **TETANUS** shot? _____

Last **FLU** shot? _____

Last **Pneumonia** shot? _____

List any previous major **INJURY** _____

Circle any **SURGERIES** you have had:

None Appendix Heart

Tonsils Uterus Hernia

Gallbladder Tubes Tied Other (list)

MALE: Testicle pain? YES NO

Discharge from penis? YES NO

Provider signature & date

Mark any problems the doctor has said **YOU** have:

HIV/AIDS		Cancer		Thyroid	
Heart		Asthma		Seizure	
Arthritis		Diabetes		Hepatitis	
Stroke		Mental Illness		High Blood Pressure	
Other:					

Please mark any medical problems that run in your immediate **FAMILY**.

DISEASE	Dad	Mom	G.Parent
Asthma			M D
Cancer-type:			M D
Diabetes			M D
Heart			M D
High Blood Pressure			M D
Mental Illness			M D
Stroke			M D
Other			M D

Do you smoke? YES NO

Packs per day? _____ For _____ years.

Do you use chewing tobacco? YES NO

Do you drink alcohol? YES NO

Daily Weekly Monthly Social

Do you use illegal drugs? YES NO

Any history of IV drug use? YES NO

Have you had a blood transfusion before the year 1992? YES NO

FEMALE: Last menstrual period _____
of pregnancies _____ # of childbirths _____
Vaginal discharge? YES NO
Breast pain? YES NO
Type of birth control? _____
Date of last pap _____ Normal Abnormal
Date of last mammogram _____

PLEASE COMPLETE BACK OF FORM

Are You Depressed?

Your health-care provider can help you find out and help you get the treatment you need to feel better.

Check any symptom you have had every day or nearly every day for the last 2 weeks.

- A deep sense of sadness or unhappiness
- A lack of interest in things you used to enjoy such as hobbies or friends
- Weight gain or loss, change in appetite
- Sleeping too much or too little
- Restlessness or decreased activity
- Fatigue or lack of energy
- Feelings of guilt, worthlessness or hopelessness
- Trouble remembering, thinking or making decisions

- I have a chronic (long-term) medical condition
- I have a family member with depression or another mental disorder
- Thoughts of death or suicide; attempted suicide. (People suffering from this symptom should get help immediately!)

Smoking History

Please look at all three sections and answer all that apply.

Section A. (Check the best answer that describes you)

- I have never smoked or have smoked less than 100 cigarettes in my lifetime.
- I stopped smoking in the year _____.
- I have been thinking about quitting but not ready yet.
- I am ready to quit within the next 30 days.

Section B. (Household Environment)

1. How many smokers do you live with? _____
2. What is your relationship to the above smoker(s),

3. Where do they smoke? _____
4. Do you allow others to smoke in your home? _____

Section C. (If you smoke or quit)

1. How many cigarettes a day do you smoke? _____
2. How many years have you or did you smoke? _____
3. If you currently smoke, how soon after awaking do you smoke?

4. Where do/did you smoke? _____
5. If you quit, when was the last time you smoked? less than 6 months 6-12 months > 1 year

Risk Factors For Hypertension

Are You At Risk?

Do you have any of these risk factors?

- I am a woman over the age of 65
- I am post-menopausal
- I am African-American
- I take birth control pills
- I smoke
- I am overweight
- I have diabetes
- I get little or no regular exercise
- I am a man over the age of 55
- I have family members with hypertension

CAGE Questionnaire

1. Have you ever felt you should cut down on your drinking?
 - YES
 - NO
2. Have people annoyed you by criticizing your drinking?
 - YES
 - NO
3. Have you ever felt bad or guilty about your drinking?
 - YES
 - NO
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
 - YES
 - NO

Dental Screening

When was your last dental visit? _____

Are you currently having any dental pain?

Please explain: _____
