Department of Health

HEALTH HISTORY

Please Note: *All information is confidential* and will become part of your medical record.
Please complete all boxes to the best of your ability
PLEASE PRINT CLEARLY.

Patient Label

Patient Name: ***Preferred Name:*** ***Date of Birth: _____/_____/_____***		**Date of Visit:**
Gender at Birth: ❑ Male ❑ Female ❑ Intersex **Preferred Pronoun:** ❑ He/him/his ❑ She/her/hers ❑ They/their/theirs ❑ Other:	**Identify As:** ❑ Male ❑ Female ❑Trans Male/Female-to-Male ❑Trans Female/Male-to-Female ❑Other: _____ ❑Prefer not to disclose	**Do you think of yourself as:** ❑ Prefer not to disclose ❑ Lesbian/Gay or Homosexual ❑ Straight or Heterosexual ❑ Bisexual ❑ Something Else, please specify: ❑ Don't Know

Allergies (Medication, Food, Latex, Bee Stings, Etc.)	Type of Reaction

Use Additional Comments for other allergies, medications, supplements etc.

Prescription and Over the Counter Medications And Supplements	How Much/How Often	Reason

Physicians and Pharmacies		
Pharmacy	**Address**	**Phone/Fax**
Primary Care Provider/Specialists	**Address**	**Phone/Fax**
PCP:		
Specialist:		

Hospitalizations/Surgeries Please include all visits/stays, procedures, even if not relevant to this visit. If no history, write none.		
Hospitalization/Surgery	**Dates**	**Description**

IF THE CHILD BEING SEEN TODAY IS UNDER 6 YEARS OF AGE COMPLETE THIS SECTION

When did you begin prenatal care?
- ❑ 1st Trimester (0-13 Weeks)
- ❑ 2nd Trimester (14-26 Weeks)
- ❑ 3rd Trimester (27-40+ Weeks)
- ❑ None ❑ Unknown

Hospital of Birth:_____
Birth Weight: _____lb _____oz OR _____kg
Birth Height: _____ in OR _____cm
❑ Delivery Complications:

❑ Newborn Complications:

❑ Neonatal Intensive Care Unit
Age at Discharge:_____ ❑ Days or ❑ Weeks

❑ Pregnancy Complications:

Group B Strep (GBS): ❑ POS ❑ Neg ❑ Unknown

❑ Premature Birth (less than 37 weeks)
Gestational Age_____(weeks)
❑ Vaginal Birth
❑ C-Section
Reason:_____

Did your baby have a Newborn Hearing Test?
❑ Yes: ❑ Passed ❑ Failed ❑ Unknown
❑ No ❑ Unknown
Did your baby have a Newborn Screen Test (Heel stick)? ❑ Yes ❑ No ❑ Unknown

ADVANCE DIRECTIVE FOR HEALTHCARE (Age 18 and above ONLY)

Example: Living Will, Durable Power of Attorney, Organ Donation, "Do Not Resuscitate" Instructions

Have you finalized any advance health directives? ❑ Yes ❑ No (see question below) **If NO**, would you like information? ❑ Yes ❑ No

Alcohol, tobacco & recreational drug use can affect your health & interfere with certain medications and treatments.
Your answers will remain confidential. (Alcohol 12 oz of beer, 5 oz of wine, 1.5 oz of liquor)

Do you drink alcohol?
- ❑ Never
- ❑ I used to drink but quit in_____(year)
- ❑ Yes
  - ❑ wine ❑ beer ❑ liquor
- ❑ I have_____drink(s) per day
- ❑ I have_____drink(s) per week
- ❑ How often do you have 5 or more drinks on one occasion? _____
- ❑ Prefer not to disclose

Do you use tobacco? (Cigarette, Vape, Snuff, Chewing)
- ❑ I never smoked or used smokeless tobacco
- ❑ Yes, I smoke ❑cigarettes ❑ cigars ❑ pipes _____ pack(s) per day for _____ years
- ❑ Yes, I use chewing or smokeless tobacco _____ (amount)per day for _____ years
- ❑ I used to smoke but quit in_____(year)

Tobacco Cessation
- ❑ I am not interested in quitting
- ❑ I am interested in quitting
- ❑ Prefer not to disclose

Do you use drugs for recreational purposes?
- ❑ Never
- ❑ No, but I have used _____
- ❑ Yes, I use _____
  - ❑ Snorted drug(s)
  - ❑ Injected drug(s)
- ❑ Prefer not to disclose

Screening(s)/Testing

PLEASE PROVIDE THE DATE AND RESULTS OF YOUR **LAST** SCREENING TO THE BEST OF YOUR KNOWLEDGE

Mammogram / Result	❑ Normal ❑ Abnormal	Date:	Notes:
Colon Screen / Result	❑ Normal ❑ Abnormal	Date:	Notes:
PAP Smear / Result	❑ Normal ❑ Abnormal	Date:	Notes:
HPV / Result	❑ Positive ❑ Negative	Date:	Notes:
HIV / Result	❑ Positive ❑ Negative	Date:	Notes:
Hepatitis C / Result	❑ Positive ❑ Negative	Date:	Notes:
Other:		Dates:	Notes:

Medical History ❑ Check here if none

General
- ❑ Obesity
- ❑ Physical Activity Limitation
- ❑ Sexual Problems
- ❑ Other:

Skin
- ❑ Eczema
- ❑ Psoriasis
- ❑ History Skin Cancer
  - ○ Melanoma ○ Basal Cell
  - ○ Squamous Cell ○ Unknown
- ❑ Other:

Head/Eyes/Ears/Nose/Throat
- ❑ Seasonal Allergies (Hay Fever)
- ❑ Chronic Sinusitis
- ❑ Glaucoma
- ❑ Vision Loss
- ❑ Hearing Loss
- ❑ Wears Contacts/Glasses
- ❑ Other:

Respiratory
- ❑ Asthma
- ❑ COPD/Emphysema
- ❑ Recurrent Bronchitis
- ❑ Cystic Fibrosis
- ❑ Sleep Apnea
- ❑ Pulmonary Embolus (lung clot)
- ❑ Lung Cancer
- ❑ Other:

Cardiovascular
- ❑ High Blood Pressure
- ❑ Valvular Heart Disease
- ❑ Congestive Heart Failure
- ❑ High Cholesterol
- ❑ Cardiovascular Disease
  - Age at Heart Attack: ____
- ❑ Irregular Heartbeat
- ❑ Pacemaker
- ❑ Peripheral Vascular Disease
- ❑ Varicose Veins
- ❑ Deep Vein Thrombosis (DVT)
- ❑ Other:

Gastrointestinal
- ❑ Hiatal Hernia
- ❑ GERD
- ❑ Ulcer
- ❑ Gallbladder Disease
- ❑ Liver Disease
  - ○ History of Hepatitis
  - ○ Fatty Liver
- ❑ Colon Disease
- ❑ Colon Cancer
- ❑ Pancreatitis
- ❑ Other:

Genitourinary
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ UTIs (bladder infections)
- ❑ Uterine Fibroids
- ❑ Abnormal Uterine Bleeding
- ❑ Hysterectomy
  - Reason: _____
- ❑ Vaginal Infections
- ❑ BPH (enlarged prostate)
- ❑ Prostate Cancer
- ❑ Testicular Cancer
- ❑ Other:

Musculoskeletal
- ❑ Arthritis
- ❑ Osteopenia/Osteoporosis
  - Last Bone Density Screen: _____
- ❑ Fracture: _____
- ❑ Joint Replacement: _____
- ❑ Fibromyalgia
- ❑ Other:

Medical History

Endocrine

- ❑ Diabetes
  - ○ Type 1 ○ Type 2
  - ○ Gestational
- ❑ Thyroid Disorder
- ❑ Thyroid Cancer
  - ○ Multiple Endocrine Neoplasia
  - ○ Medullary Thyroid Cancer
- ❑ Other:

Neurologic

- ❑ Cerebral Aneurysm
- ❑ Stroke
- ❑ Traumatic Brain Injury
- ❑ Brain Tumor
- ❑ Parkinson's Disease
- ❑ Dementia
- ❑ Seizure Disorder/Epilepsy
- ❑ Neuropathy
- ❑ Migraines/Headaches
- ❑ Developmental Delay
- ❑ Intellectual Disability
- ❑ Other:

Psychiatric

- ❑ Anxiety
- ❑ Depression
- ❑ Bipolar
- ❑ PTSD (Post Traumatic Stress)
- ❑ Eating Disorder
- ❑ Suicidal Thoughts
- ❑ Other

Would you like to discuss any concerns?

Hematologic (Blood)

- ❑ Bleeding Disorder
- ❑ Clotting Disorder
- ❑ Anemia
- ❑ Sickle Cell
  - ○ Disease
  - ○ Trait
- ❑ Other:

Infectious

Have you ever had:

- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Tuberculosis
- ❑ Sexually Transmitted Infection
  - ○ Chlamydia ○ Gonorrhea
  - ○ Syphilis ○ Herpes
  - ○ Other:
- ❑ MRSA (Staph)
  - ○ Infection ○ Abscess
- ❑ Recurrent Abscesses
- ❑ Chicken Pox
- ❑ Measles
- ❑ Mumps
- ❑ Other:

Cancer

- ❑ Type/Location: _____
  _____
  Age at Diagnosis: _____
- ❑ Type/Location: _____
  _____
  Age at Diagnosis: _____
- ❑ Type/Location: _____
  _____
  Age at Diagnosis: _____
- ❑ Type/Location: _____
  _____
  Age at Diagnosis:

Other

- ❑ Birth Defect
- ❑ Genetic Condition
  Describe: _____
- ❑ Other:

Immunizations: Include date if known

- ❑ Influenza: _____
- ❑ Pneumonia: _____
- ❑ Last Tetanus: _____
- ❑ Hepatitis A: _____
- ❑ Hepatitis B: _____
- ❑ MMR: _____
- ❑ Chickenpox: _____
- ❑ Zoster (Shingles): _____
- ❑ HPV: _____
- ❑ Meningococcal: _____
- ❑ COVID-19: _____
- ❑ Other:

Include clinic/office of vaccine if known

Family History: Check for Mother, Father, Sibling or Child Only

☐ Check here if family history unknown

Mother

- ❑ Heart Disease
  Age of onset: _____
- ❑ Diabetes
  - Type 1 or Type 2
    Age of onset: _____
- ❑ Cancer
  Type: _____
  Age of onset: _____
- ❑ Mental Illness
  Type: _____
  Age of onset: _____
- ❑ Genetic Condition:
  Type: _____
- ❑ Other:
- ❑ Other:
- ❑ Deceased:
  - Age

Father

- ❑ Heart Disease
  Age of onset: _____
- ❑ Diabetes
  - Type 1 or Type 2
    Age of onset: _____
- ❑ Cancer
  Type: _____
  Age of onset: _____
- ❑ Mental Illness
  Type: _____
  Age of onset: _____
- ❑ Genetic Condition:
  Type: _____
- ❑ Other:
- ❑ Other:
- ❑ Deceased:
  - Age

Sibling

- ❑ Heart Disease
  Age of onset: _____
- ❑ Diabetes
  - Type 1 or Type 2
    Age of onset: _____
- ❑ Cancer
  Type: _____
  Age of onset: _____
- ❑ Mental Illness
  Type: _____
  Age of onset: _____
- ❑ Genetic Condition:
  Type: _____
- ❑ Other:
- ❑ Other:
- ❑ Deceased:
  - Age

Child

- ❑ Heart Disease
  Age of onset: _____
- ❑ Diabetes
  - Type 1 or Type 2
    Age of onset: _____
- ❑ Cancer
  Type: _____
  Age of onset: _____
- ❑ Mental Illness
  Type: _____
  Age of onset: _____
- ❑ Genetic Condition:
  Type: _____
- ❑ Other:
- ❑ Other:
- ❑ Deceased:
  - Age

Caution: Personal Questions on Back

****COMPLETE ONLY IF NEEDED, NOT REQUIRED FOR ALL VISITS****

MALE ONLY: REPRODUCTIVE AND SEXUAL HISTORY	
Have you experienced physical or sexual abuse?	
SEXUAL HEALTH HISTORY	**REPRODUCTIVE LIFE PLAN** ❑ Prefer not to disclose
Have you ever had sex? ❑Yes ❑No ❑Prefer not to disclose	Do you have any children now? ❑Yes ❑No ❑Unknown
Have you had sex with: ❑Women ❑Men ❑Both	When, if ever, would you like to have (more) children?
Does a sex partner use IV street drugs ❑Yes ❑No ❑Unknown	❑Yes ❑No intention
Has a sex partner ever had: ❑STI ❑HIV ❑Both	❑Not Applicable ❑Unsure or okay either way
Have you ever had: ❑Chlamydia ❑Gonorrhea ❑Other:	What method of birth control are you using?

FEMALE ONLY: REPRODUCTIVE AND SEXUAL HISTORY	
Have you experienced physical or sexual abuse?	
OB / GYN HISTORY	**SEXUAL HEALTH HISTORY**
Have you ever had a period? ❑ Yes ❑ No ❑ Prefer not to disclose	Have you ever had sex? ❑ Yes ❑ No ❑ Prefer not to disclose
How old were you when you started your period?	How old were you the first time you had sex?
How often do you have periods?	Have you had sex with: ❑ Women ❑ Men ❑ Both
How many days do your period last?	Does a sex *partner* use IV street drugs? ❑ Yes ❑ No ❑ Unknown
My bleeding is… ❑ Heavy ❑ Light ❑ Medium	Has a sex *partner* ever had: ❑ STI ❑ HIV ❑ Both
Do you have cramps with your period? ❑ Yes ❑ No ❑ Unsure	Have you ever had: ❑ Chlamydia ❑ Gonorrhea ❑ Other:
What medicine do you take for cramps?	
Bleeding or spotting between periods? ❑ Yes ❑ No ❑ Unsure	
Bleeding/spotting after sex/intercourse? ❑ Yes ❑ No ❑ Unsure	
Have you ever had been pregnant? ❑ Yes ❑ No ❑ Decline	**REPRODUCTIVE LIFE PLAN** ❑ Prefer not to disclose
Age of first pregnancy?	What method of birth control are you using?
Used Fertility Medications? ❑ Yes ❑ No ❑ Unsure	Would you like to have (more) children?
Fertility Procedures? (IVF) ❑ Yes ❑ No ❑ Unsure When was your last delivery?	❑ Yes ❑ No intention ❑ Unsure or okay either way
Did you have check-up after last delivery? ❑ Yes ❑ No Date	
Are you breastfeeding right now? ❑ Yes ❑ No ❑ Decline	
Did your mother take DES (hormones) while pregnant? ❑ Yes ❑ No ❑ Unsure	

Additional Comments/Information