Date_____ MedicalRecord#:_____(office)

Personal Health History Form

Name: Last_____First_____Middle/Maiden_____
Age_____ Gender Identification_____
Please describe the major reason for this visit?

Please list any other significant concerns that you currently have:

Medical History
Have you had any major illnesses or hospitalizations that have caused you to miss work, school, or change your lifestyle? Yes ____ No ____If yes, please list

Please list any surgeries you have had:

Describe below any past problems or current concerns regarding reproduction or sexual function

Please list your pregnancies below

TYPE	Number	Associated problems/comments	
Vaginal Births			
Caesarian Sections			
Miscarriages			
Terminations			

When was the first day of your last period? _____
How often do you have a period? _____How long does each period last? _____
Do you have any other vaginal discharge that is bothersome?_____We recommend safe sexual practices. Are you currently sexually active? _____ Do you practice safe sex? _____Would you like testing for STD's?_____Do you have a regular partner? _____ Is your partner male or female or both?_____
Are you planning a pregnancy now? _____ If not, what birth control method are you using? _____Would you like information about other methods? _____

What **allergies** do you have currently (foods, medications, environmental, or latex)? What type of reaction do you have?

What **medications** do you currently take and why? (Include over the counter medications, vitamins, and herbal remedies)

Medications	Dose	Frequency	Reason for taking

What alternative health remedies do you use? (Massage, acupuncture, etc)

Family History Have any of your relatives had the following diagnoses?

	Yes	Which relative
Heart disease		
Stroke		
High blood pressure		
High Cholesterol		
Diabetes		
Thyroid disease		
Breast cancer		
Other Cancer(s)		
Depression		
Mental Health Hospitalization		
Suicide attempt		
Osteoporosis		

Social History

We recommend limiting tobacco use. How much tobacco do you use a day? _____
For how many years_____How much alcohol do you use a day? _____
What recreational drugs do you use? _____ How often?_____

Please circle you current stress level no stress 1 2 3 4 5 6 7 8 9 10 severe
What is you biggest source of stress right now?
What do you do to relieve stress?
What are the things that bring you your greatest happiness?
Are you currently employed? Yes__ No __If yes, what is your job and are you concerned about any work related health hazards?
Do you like your job? Yes _____No _____
Do you have any financial concerns that limit your ability to seek health care? Yes_____No_____
What is your Marital Status: Single___Co-habitating ___Married____Divorce___Widowed___
What cultural, religious, or spiritual issues do you have that might influence your health care?

Preventive Health Care and Screening

When was your last tetanus shot? _____ last pap smear?_____ mammogram?_____
breast self exam?_____ cholesterol screen? _____
dental check?_____bone scan? _____ colonoscopy?_____
Do you follow a healthy diet? _____If not, would you like information on nutrition or weight control?_____
Consider your physical activity during the last month and circle the statement that best describes your exercise habits:

How often do you exercise aerobically?	How long do you exercise?
Daily or almost daily	Over 45 minutes per session
3 - 5 times a week	30 – 45 minutes per session
1 - 2 times a week	20 – 30 minutes per session
A few times a month	10 -20 minutes per session
Less than once a month	Less than 10 minutes per session

Circle the types of activities that you perform? Strength Training, Walking, Sports, Running, Yoga, Swimming, Cycling, Housework/Yard work, Hiking, Flexibility Exercise,
Other: _____
Would you like information on exercise, fitness, strength, or flexibility training? _____
How many hours do you sleep each night? _____
We recommend safety belt use in cars and helmets with motorcycles.
Do you wear a safety belt or helmet when driving? _____
We recommend avoiding alcohol when driving. Do you drink alcohol and drive a car or boat?_____
Have you ever been sexually or physically abused? _____
Is anyone hurting you now?_____
Is there a firearm in your house? _____ We recommend safe storage or removal.
We recommend use of smoke detectors in the home. Do you have a smoke detector? _____
We recommend limiting sun exposure. Do you have recreational or occupational sun exposure? _____
If you are a woman of child bearing age we recommend O.4 mg of folic acid/day. If you are ‹18 yrs old or post menopausal we recommend 1200 mg of calcium /day.

Risk Factor Assessment

Please check any of the following risk factors to cervical cancer that apply to you

___Prior history of abnormal pap
___Exposure to any sexually transmitted diseases- including herpes,HIV, HPV, gonorrhea, syphilis, or chlamydia
____History of a blood transfusion
____Onset of first sexual activity prior to age 16
____ Smoking ____DES
____› 5 sexual partners in a lifetime

Please check any risk factors for osteoporosis that apply to you

____Use of steroids current or past
____Family history
____Smoking
____Underweight ____ Caucasian

Please check any of the risk factors for diabetes that apply to you

____Family history
____History of diabetes in a pregnancy or delivery of a baby ›9 lbs
____Overweight
____High Blood pressure

Please check any of the following risk factors for breast cancer that apply to you

____Family history
____History of menstruation prior to age 12

____History of menopause after age 52 ____History of a biopsy showing hyperplasia

Please check any of the following risk factors for heart disease that apply to you

____Smoking ____History of high cholesterol in you

____History of heart attack in a family member especially if <55 yrs of age or a family member

____Diabetes

If you have a problem now, or if you have had a problem with any of the following body systems in the past, please check and explain at the bottom. Thank you. If it was in the past mark with a "P"

Cardiovascular

____Blood pressure ____Chest pain-angina

____Heart ____ Failure

____Heart attack ____Blood vessels

____Murmur-valve problem

Respiratory

____ Lungs (Breathing problem, Asthma, TB)

____ cough ____ wheezing

____ shortness of breath

Gastrointestinal

____ Abdomen (constipation, ulcers)

____ Rectum (hemorrhoids, incontinence)

____ Liver (hepatitis)

Endocrine

____ Diabetes

____ Thyroid

Eyes, Ear, Nose, Throat

____ Eyes ____ Mouth

____ Ears ____ Throat

____ Nose and Sinuses

Psychiatric

___ Schizophrenia ___ Anxiety

____ Depression __ Eating DO

Musculoskeletal

____ Joints (arthritis)

____ Muscles

____ Bones

Dermatologic

____ Skin/rashes, moles, ulcers

____ Lymph nodes

General

____ Insomnia ____ Fatigue

Neurological

____ Loss of sensation ____ Loss of strength

____ Memory loss ____ Dizziness/fainting

____ Migraines or headaches ____seizures

Hematologic

____ Anemia ____ Blood clots

____ Easy Bleeding ____ HIV

____ Blood transfusion

Genitourinary

____ Breast _____ Vagina

____ Uterus _____ Tubes

____ Ovaries _____ Cervix

_____ Pelvic Infection

____ Kidney

Other problems/risks

_____Lack of care giver or support ____Need for case management ____Inadequate housing or food

_____Language barrier to care ___Financial barriers to care ___ Needing help with self care

Would you like us to share a summary of your care today with your Primary care provider

Yes___ No_____ Name of provider _____

Signature_____