Health History Form

Date Completed: _____

Patient Name: _____

Date of Birth: _____

Past Medical History

	Y	N
Asthma		
Chronic Bronchitis		
Respiratory Disorders		
Hypertension		
Heart Disease		
Nonmoving Limbs (paralysis)		
Numbness		
Seizure Disorder		
Dizziness/Fainting (syncope)		
Blood Clots		
Eyesight Problems		
Headache Syndromes		
Hearing Loss		
Hyperlipidemia		
Ulcers		
Liver, Stomach, or Bowel Disease		
ADD/ADHD		
Skin Disorders		
Stroke/TIA		

	Y	N
Eating/Swallowing Disorder		
Backache		
Spine Disorders		
Arthritis		
Rheumatoid Arthritis		
Renal Disease		
Urinary Problems		
Hepatitis		
Gallbladder Disease		
Diabetes Mellitus		
Thyroid Disease		
Cancer		
Bleeding(Hematology) Disease		
Venereal Disease (STD)		
Mental Health(anxiety/depression)		
HIV Infection		
Peripheral Neuropathy		
Osteoporosis/Osteopenia		
Pain		

For "Yes" responses, please provide additional information if applicable: _____

Surgical History

HEENT Sugery	Y	N
Eyes/Ears/Nose/Throat Surgery		
Cataract/Lens Implant		
Thyroid Surgery		
Tonsils Removed		

Date: _____

Cardiovascular Sugery	Y	N
Aortic Aneurysm Repair		
Angioplasty		
Coronary Artery Bypass Graft		
Other Cardiothoracic Surgery		
Coronary Angiography		
Pacemaker/Defibrillater		

Date: _____

Breast	Y	N
Mastectomy		
Breast Biopsy		

Date: _____

GI Surgery	Y	N
Abdominal		
Appendix Removed		
Gallbladder Removed		
Colectomy, partial		
Gastric Bypass or Lap-band		
Stomach Surgery, Other		
Hernia		
Intestinal bypass		
Bowel Adhesion Removed		
Small Bowel Surgery		
Ulcer Surgery		

Date: _____

Derm Surgery	Y	N
Skin		
Mole Removal		
Malignant		
Benign		

Date: _____

Ortho Surgery	Y	N
Orthopedic Surgery, Other		

Date: _____

Surgical History Continued

Neuro Surgery	Y	N
Back Surgery		
Carpal Tunnel		
Laminectomy/Discectomy		
Neurosurgery		

Date: _____

GYN/GU	Y	N
Cesarean Section		
Hysterectomy		
Oophorectomy		
Bladder Surgery		
Prostate Surgery		
TURP		
Lithotripsy		
Kidney Surgery, Other		
Tubal ligation		
Gynecologic Surgery, Other		
GU Surgery, Other		

Is there any other information regarding your surgical history that we should know about?

_____

_____

_____

Social History

Education/Work History

Years of education completed: _____

Education Level: _____

	Y	N
Working Full Time		
Working Part Time		
Currently on Disability		
Other work history		
Retired		

Work History (Occupation): _____

Living Situation	Y	N
Living with spouse		
Living alone		
Living with parents		
Other living situations		
Living in a nursing home		

Other living arrangements: _____

_____

Home Living Environment	Y	N
Secure & Supportive		
Domestic Violence		
Fear of Other Occupants		

Marital/Social	Y	N
Currently Married		
Previously Married		
Never Married		
Single		
Seperated		
Divorced		
Widowed		
Religious affiliation		
Military history		
Sexually active		

Substance Use	Y	N
Coffee		

Cups/daily: _____

Alcohol History	Y	N
Alcohol Use		
Never drank alcohol		
Being a social drinker		
Heavy alcohol consumption		

Tobacco History	Y	N
Previous Smoker		
Chew Tobacco		
Smoke Cigarettes		

How long? _____

How many packs/day? _____

Drug History	Y	N
Drug Use		
Using Marijuana		
Using Cocaine		
Using Intravenous Drugs		

How long: _____

Family History

	Mother	Father	Brother	Sister	Son	Daughter
Diabetes Mellitus						
Tuberculosis						
Heart Disease						
Hypertension (high B/P)						
Stroke Syndrome						
Cancer						
Seizure Disorder						
Mental Illness (not MR)						
Bleeding Problems						
Anemia						
Autoimmune Disease						
Thyroid Disorders						
TIA (Mini-Stroke)						
Migraine Headaches						
Neurology						
Backache						
Genetic Disease						
Birth Defects						
Kidney Disease						
Alcoholism						
Chronic Disabling Disease						
Other:						

Mother's Health Status

Mothers Age: _____

Mother deceased at age: _____

Father's Health Status

Father's Age: _____

Father Deceased at age: _____

Immunizations	Date:
Influenza (flu)	_____
H1N1	_____
Pneumonia	_____
Tetanus	_____
Other:	_____
Other:	_____

Health Maintenance	**Date:**
Dental	_____
Eye Exam	_____
Mammogram	_____
PAP Smear	_____
Abnormal PAP	_____
Bone Density Scan	_____
Colonoscopy	_____

Is there any other information regarding your past medical history that we should know about?

_____

_____

_____

Coal Country Community Health Center
Health Screening Questionnaire
(12 years of age and older)

Have you been seen by a healthcare provider in the last 6 months? If so, who and where?

Have you had any changes to your medications?

Anxiety & Depression Screening:

Over the past two weeks, have you been bothered by any of the following problems?

Feeling nervous, anxious or on edge?	YES	NO
Not being able to stop or control worrying?	YES	NO
Little interest or pleasure in doing things?	YES	NO
Feeling down, depressed, or hopeless?	YES	No

Alcohol, Substance, and Tobacco Use Screening

Have you ever felt you ought to cut down on your drinking or drug use?	YES	NO
Have people annoyed you by criticizing your drinking or drug use?	YES	NO
Have you ever felt bad or guilty about your drinking or drug use?	YES	NO
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	YES	NO
Are you a tobacco user?	YES	NO
Are you interested in receiving information about stopping tobacco use?	YES	NO

Breast Cancer Screening:
When and where did you have your last mammogram?
(Female: Age 40 – 74 years of age)

Cervical Cancer Screening: When and where did you have your last PAP smear test?
(Female: Age 21-65 years of age)

Colorectal Cancer Screening:
When and where did you have your last colonoscopy or flexible sigmoidoscopy?
When and where did you have your fecal occult blood test (FOBT /FIT)?
(Male and Female: Age 50-75 years of age)

Do you have any problems with your teeth or mouth?

Have you received the following recommended immunizations?

Influenza (Flu vaccine) once every year	YES	NO
Pneumococcal (Pneumonia vaccine) if > 65 years of age or tobacco user	YES	NO
Td/Tdap (Tetanus, diphtheria and acellular pertussis) once every 10 years	YES	NO
Varicella (Chickenpox vaccine) 2 doses ever	YES	NO
Zostavax (Shingles vaccine) if > 60 years – once per lifetime	YES	NO
Gardasil (Human Papilloma Virus vaccine) 11-26 years old (3 dose series)	YES	NO

Name:		**Date of Birth:**	

TODAY'S DATE: ___/___/_____