

Name _____ Date _____

Date of Birth _____ Sex F ___ M ___

Allergies to Medications / Latex – please include type of reaction
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Please list **current medications** Include Herbal and over the counter medications
Include dose and how many times a day drug is taken

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Surgical History - Hospitalization

Illness/ Surgery/Injury/Condition	Illness/ Surgery/Injury/Condition
1.	4.
2.	5.
3.	6.

Medical History

Have you had any of the following?		Please specify and give details
Diabetes (include pregnancy)	Yes No	
Heart Disease	Yes No	
Kidney Disease	Yes No	
Sickle Cell Anemia	Yes No	

Have you had any of the following?		Please specify and give details
Spleen removed	Yes No	
Alcoholism or heavy alcohol use	Yes No	
Hepatitis or Cirrhosis	Yes No	
Cancer	Yes No	
Mitral Valve Prolapse	Yes No	
Rheumatic Fever	Yes No	
An artificial heart valve	Yes No	
Endocarditis(heart valve infection)	Yes No	
Tuberculosis(or positive skin test)	Yes No	
High cholesterol (level and date)	Yes No	
High blood pressure	Yes No	
A heart attack	Yes No	
Coronary bypass surgery	Yes No	
Angina/ chest pain	Yes No	
A stroke or TIA (mini stroke)	Yes No	
Atrial fibrillation (or irregular beat)	Yes No	
Ovaries removed before menopause	Yes No	
Venereal disease (syphilis, gonorrhea, chlamydia, herpes)	Yes No	
AIDS or the AIDS virus (HIV)	Yes No	
Other problems:		

Smoking: Do you Smoke? Yes___ No___ Have you ever smoked? Yes___ No___
Number of years__ Cigarettes __ Cigars __ Pipe __ Packs per day_____

Nutrition:

Have you lost or gained 10 or more pounds in the last month? Yes___ No___
Significant problems swallowing or chewing? Yes___ No___
Decrease in appetite? Yes___ No___

Exercise: Do you exercise regularly? Yes___ No___
How often and what type of exercise?_____

Alcohol: How many drinks do you have a day? (include what type)

Drugs: Do you now or have you ever used drugs (cocaine, heroin)? Yes___ No___
Have you ever used I. V. drugs (with needles) Yes___ No___
If so, when was the last time? _____

Sexual History: Do you have any risk factors of AIDS? (multiple partners, homosexual intercourse, sex with a prostitute, history of sexually transmitted disease)
Yes___ No___

Women only: How many times have you been pregnant?_____ Live births _____
Miscarriages_____ Abortions _____
When was your last menstrual period?_____ Are cycles regular? Yes No
Date of your last pap smear _____ Year of your last mammogram _____
Do you do self breast exam? How often? _____

Men only: What year was your last rectal/prostate exam? _____
Do you have difficulty starting your stream or with dribbling ? Yes___ No___

Social History

Who lives at home with you (name, relationship, and age)?

Family Members

	List health problems ----use listing below.
Father	
Mother	
Brother(s)	
Sister(s)	
others	

Heart Disease, High Blood pressure, Diabetes, Emphysema, Kidney Disease, High Cholesterol, Stroke, Glaucoma, Alzheimer's, Tuberculosis, Bleeding Tendency, Cancer (name type), Osteoporosis, Birth Defects, Miscarriage

Educational background: Grade School___ HS___ College___ other___

Preferred method of learning: Reading___ Discussion___ Demonstration___

Hearing___ Doing___

Primary language: English___ Spanish___ Other_____

List any other information about yourself that would be helpful when we provide you with health teaching :

Environmental Exposure: Has your job or hobby exposed you to toxic substances (pesticides, solvents or asbestos) Yes___ No___

Advanced Directives: Do you have an Advanced Directive Yes___ No___

If, Yes what type? Health Care Proxy___ Living Will ___ DNR___

If No, would you like to complete one? Yes___ No___

(Office use only-Directives given_____ Patient Rights given_____)

Pain Screen: Have you had pain in the last week? Yes___ No___

On scale on 0-10 (0=no pain, 10 being the worst pain) , how would you rate your worst pain this week? 0 1 2 3 4 5 6 7 8 9 10

If you rated your pain 4 or greater, please answer the following questions.

Where is you pain located? _____

Describe the pain (stabbing, cramping, sharp, dull, spasms) _____

How long have you had pain? _____

What relieves the pain? _____

Does your pain limit your activities? _____

What increases the pain? _____

Are you taking medication(s)? List _____

Are you using other treatments for your pain? _____

Within the last year, have you been verbally, emotionally, sexually or physically harmed or threatened by your partner or any one else? Yes___ No___

Within the last year, have you felt afraid or unsafe with your partner or any one else? Yes___ No___

Do you wear a seat belt when you drive? Always___ Usually___ Seldom___ Never___

Do you wear a bike helmet when cycling? Always___ Usually___ Seldom___ Never___

Do you have a smoke detector in your house? Yes___ No___

Do you have a carbon monoxide detector in your house? Yes___ No___

Do you own a gun? Yes___ No___

(form 101)

