HEALTH HISTORY

Name: _____ DOB: _____ RPMS #: _____ Date: _____

Past Medical History: ***Please check all that apply to you and date of onset***

☐ Stroke/TIA _____	☐ High blood pressure _____	☐ Diarrhea _____
☐ Headaches _____	☐ High cholesterol _____	☐ Constipation _____
☐ Fainting spells _____	☐ Heart Attack _____	☐ GERD _____
☐ Epilepsy (*seizures*) _____	☐ Heart arrhythmia _____	☐ Stomach ulcer _____
☐ Fatigue _____	☐ Chest pain _____	☐ IBS _____
☐ celiac _____	☐ Depression _____	☐ Anemia (*sickle cell or other*) _____
☐ Crohn's _____	☐ Anxiety _____	☐ Diabetes (*type I or II*) _____
☐ Blood in stool _____	☐ Bipolar _____	☐ Thyroid disease (*high/low thyroid*) _____
☐ Fatty Liver _____	☐ Suicide attempt _____	☐ Kidney disease _____
☐ Cirrhosis _____	☐ Alcoholism _____	☐ Dialysis _____
☐ Hepatitis _____	☐ Abuse _____	☐ Eating disorder _____
☐ Arthritis/Joint disease _____	☐ HIV positive _____	☐ Osteoporosis _____
☐ STI _____	☐ Sleep Apnea _____	☐ Muscle/bone problems _____
☐ Cancer Type _____	☐ Asthma _____	☐ Serious injury or accident _____
☐ Chronic pain _____	☐ Pneumonia _____	☐ Weight problem (*over/under*) _____
☐ Prostate problems _____	☐ COPD/Emphysema _____	☐ Urinary difficulties _____

Any other health problem: _____

_____

_____

Previous Surgeries & Year:

_____

_____

Family History:
Key codes: M-Mom D-Dad GP-Grandpa GM-Grandma A-Aunt U-Uncle S-Sister B-Brother

____ Dementia	____ High blood pressure	____ COPD
____ Seizure/epilepsy	____ High cholesterol	____ Asthma
____ Anxiety	____ Stroke/TIA	____ Tuberculosis
____ Depression	____ Heart failure or disease	
____ Bipolar	____ Heart attack	____ Cancer (type: _____)
____ Alcoholism	____ Irregular heart (atrial fibrillation, etc.)	____ Cancer (type: _____)
____ Suicide/attempt suicide	____ Anemia (sickle cell or other	____ Cancer (type: _____)
____ Diabetes	____ Stomach Ulcers	____ Kidney disease
____ Hypo/Hyper Thyroid	____ Digestive (colitis, crohn's, etc.)	____ Dialysis
____ Rheumatoid Arthritis	____ Irritable bowel syndrome	

Please list whether your relatives noted with diseases are: Living: _____ Deceased: _____

Allergies: _____

Current Medications: (*Medication dosage and quantity taken per day*)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Social History:
Current employment: _____

How much and what type of exercise do you do (*Please circle*)? Walk | Run | Bike | Swim | Other: _____
☐ No activity ☐ 15 minutes ☐ 30 minutes ☐ 45 minutes ☐ 60 minutes/more Days per week you exercise _____

Tobacco use:
☐ Non-tobacco user
☐ Current smoker; Amount/day: _____
☐ Previous smoker; Quit year: _____
☐ Smokeless tobacco only
☐ Ceremonial use only
☐ Smoker in home

Drug use:
☐ None
☐ Marijuana
☐ Heroin
☐ Meth
☐ Rx drugs (*illegally obtained*)
How often? _____

Alcohol use (*Please check appropriate responses*): ☐ Do not drink _____ ☐ Drinks/week _____

Currently or Historically (*list year* _____):

1) Have you ever felt like you should cut down on your drinking?	☐ Yes	☐ No
2) Have people annoyed you by criticizing about your drinking?	☐ Yes	☐ No
3) Have you ever felt bad or guilty about your drinking?	☐ Yes	☐ No
4) Have you ever had to have a drink first thing in the AM to get rid of a hangover?	☐ Yes	☐ No

Screenings - List date of last: Colonoscopy: _____ Mammogram: _____ Bone Density Test: _____

Sexual Activity: Please circle/fill in answers Are you sexually active: ☐ Yes or ☐ No, Number of partners in the past 12 months? _____ Are your partners: ☐ Female or ☐ Male or ☐ Both

Men Only:
Do you have: ☐ Prostate problems ☐ Testicular cancer ☐ Vasectomy ☐ Sexual dysfunction

Women Only:
Do you still have menstrual periods ☐ Yes ☐ No
If no, menopausal year: _____ any post-menopausal bleeding ☐ Yes ☐ No

Reproductive History:

- Age at 1st period: _____
- First day of last menstrual period: _____ Number of days between periods: _____
- Usual flow: ☐ Heavy ☐ Moderate ☐ Light
- Do you have:
  - Painful periods ☐ Yes ☐ No
  - Spotting between periods ☐ Yes ☐ No
- Date of last pap: _____ History of abnormal pap's? ☐ Yes ☐ No
- Number of pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____

Contraceptive History: *Please check the method of contraception you are **currently** using*

☐ Birth control pills ☐ Tubal ligation ☐ IUD (*type and year placed*): _____
☐ Diaphragm/cap ☐ Hysterectomy ☐ Implant: (*year placed*): _____
☐ Condoms ☐ Partner with vasectomy

Sign/print: _____ Date: _____