N.E. Washington Health Programs

Confidential Health History

Name: ____________________ Today's Date: __________

Age: ______ Birthdate: __________ Date of Last Physical Examination: __________

What is your reason for visit? ____________________

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ❒ Chills
- ❒ Depression
- ❒ Dizziness
- ❒ Fainting
- ❒ Fever
- ❒ Forgetfulness
- ❒ Headache
- ❒ Loss of sleep
- ❒ Loss of weight
- ❒ Nervousness
- ❒ Numbness
- ❒ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ❒ Arms
- ❒ Hips
- ❒ Back
- ❒ Legs
- ❒ Feet
- ❒ Neck
- ❒ Hands
- ❒ Shoulders

GENITO-URINARY
- ❒ Blood in urine
- ❒ Frequent urination
- ❒ Lack of bladder control
- ❒ Painful urination
- ❒ Other

GASTROINTESTINAL
- ❒ Appetite poor
- ❒ Bloating
- ❒ Bowel changes
- ❒ Constipation
- ❒ Diarrhea
- ❒ Excessive hunger
- ❒ Excessive thirst
- ❒ Gas
- ❒ Hemorrhoids
- ❒ Indigestion
- ❒ Nausea
- ❒ Rectal Bleeding
- ❒ Stomach pain
- ❒ Vomiting
- ❒ Vomiting blood

CARDIOVASCULAR
- ❒ Chest pain
- ❒ High blood pressure
- ❒ Irregular heart beat
- ❒ Low blood pressure
- ❒ Poor circulation
- ❒ Rapid heart beat
- ❒ Swelling of ankles
- ❒ Varicose veins

EYE, EAR, NOSE, THROAT
- ❒ Bleeding gums
- ❒ Blurred vision
- ❒ Crossed eyes
- ❒ Difficulty swallowing
- ❒ Double vision
- ❒ Earache
- ❒ Ear discharge
- ❒ Hay fever
- ❒ Hoarseness
- ❒ Loss of hearing
- ❒ Nosebleeds
- ❒ Persistent cough
- ❒ Ringing in ears
- ❒ Sinus problems
- ❒ Vision – Flashes
- ❒ Vision - Halos

SKIN
- ❒ Bruise easily
- ❒ Hives
- ❒ Itching
- ❒ Change in moles
- ❒ Rash
- ❒ Scars
- ❒ Sore that won't heal

MEN ONLY
- ❒ Breast lump
- ❒ Erection difficulties
- ❒ Lump in testicles
- ❒ Penis discharge
- ❒ Sore on penis
- ❒ Other

WOMEN ONLY
- ❒ Abnormal Pap smear
- ❒ Bleeding between periods
- ❒ Breast lump
- ❒ Extreme menstrual pain
- ❒ Hot flashes
- ❒ Nipple discharge
- ❒ Painful intercourse
- ❒ Vaginal discharge
- ❒ Other

Date of last menstrual period? __________

Date of last Pap Smear? __________

Have you had a Mammogram? __________

Are you pregnant? ______

Number of children ______

CONDITIONS Check (✓) conditions you have or have had in the past.

- ❒ AIDS
- ❒ Alcoholism
- ❒ Anemia
- ❒ Anorexia
- ❒ Appendicitis
- ❒ Arthritis
- ❒ Asthma
- ❒ Bleeding Disorders
- ❒ Breast Lump
- ❒ Bronchitis
- ❒ Bulimia
- ❒ Cancer
- ❒ Cataracts
- ❒ Chemical Dependency
- ❒ Chicken Pos
- ❒ Diabetes
- ❒ Emphysema
- ❒ Epilepsy
- ❒ Glaucoma
- ❒ Goiter
- ❒ Gonorrhea
- ❒ Gout
- ❒ Heart Disease
- ❒ Hepatitis
- ❒ Hernia
- ❒ Herpes
- ❒ High Cholesterol
- ❒ HIV Positive
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Measles
- ❒ Migraine Headaches
- ❒ Miscarriage
- ❒ Mononucleosis
- ❒ Multiple Sclerosis
- ❒ Mumps
- ❒ Pacemaker
- ❒ Pneumonia
- ❒ Polio
- ❒ Prostate Problem
- ❒ Psychiatric Care
- ❒ Rheumatic Fever
- ❒ Scarlet Fever
- ❒ Stroke
- ❒ Suicide Attempt
- ❒ Thyroid Problems
- ❒ Tonsillitis
- ❒ Tuberculosis
- ❒ Typhoid Fever
- ❒ Ulcers
- ❒ Vaginal Infections
- ❒ Venereal Disease

MEDICATIONS List medication you are currently taking	ALLERGIES to medication or substances
Pharmacy __________ Phone# __________	

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relative had any of the following:

✓	Disease	Relationship to you
	Arthritis	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

Have you ever had a blood transfusion? ❒ Yes ❒ No

If yes, please give approximate dates. ____________________

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS Check (✓)which substances you use and describe how much you use.

✓	Substance	Amount
	Caffeine	
	Tobacco	
	Drugs	
	Other	

IMMUNIZATIONS

Tetanus	❒ Yes	❒ No	Pneumovax	❒ Yes	❒ No
Hepatitis A	❒ Yes	❒ No	Flu Vaccine	❒ Yes	❒ No
Hepatitis B	❒ Yes	❒ No	TB Screening	❒ Yes	❒ No
Childhood Imm.	❒ Yes	❒ No			
Other:					

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

✓	
	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ Signature ______________________________ Date

______________________________ Signature ______________________________ Date