

# 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	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN ONLY
<input type="checkbox"/> Chills	<input type="checkbox"/> Appetite poor	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Depression	<input type="checkbox"/> Bloating	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Erection difficulties
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Bowel changes	<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Lump in testicles
<input type="checkbox"/> Fainting	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Penis discharge
<input type="checkbox"/> Fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Double vision	<input type="checkbox"/> Sore on penis
<input type="checkbox"/> Forgetfulness	<input type="checkbox"/> Excessive hunger	<input type="checkbox"/> Earache	<input type="checkbox"/> Other
<input type="checkbox"/> Headache	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Ear discharge	<b>WOMEN ONLY</b>
<input type="checkbox"/> Loss of sleep	<input type="checkbox"/> Gas	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Abnormal Pap smear
<input type="checkbox"/> Loss of weight	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Breast lump
<input type="checkbox"/> Numbness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Extreme menstrual pain
<input type="checkbox"/> Sweats	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Hot flashes
<b>MUSCLE/JOINT/BONE</b>		<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Nipple discharge
Pain, weakness, numbness in:		<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Painful intercourse
<input type="checkbox"/> Arms	<input type="checkbox"/> Hips	<input type="checkbox"/> Vision – Flashes	<input type="checkbox"/> Vaginal discharge
<input type="checkbox"/> Back	<input type="checkbox"/> Legs	<input type="checkbox"/> Vision - Halos	<input type="checkbox"/> Other
<input type="checkbox"/> Feet	<input type="checkbox"/> Neck	<b>SKIN</b>	
<input type="checkbox"/> Hands	<input type="checkbox"/> Shoulders	<input type="checkbox"/> Bruise easily	Date of last menstrual period? _____
<b>GENITO-URINARY</b>		<input type="checkbox"/> Hives	Date of last Pap Smear? _____
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Irregular heart beat	<input type="checkbox"/> Itching	Have you had a Mammogram? _____
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Change in moles	Are you pregnant? _____
<input type="checkbox"/> Lack of bladder control	<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Rash	Number of children _____
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Rapid heart beat	<input type="checkbox"/> Scars	
<input type="checkbox"/> Other	<input type="checkbox"/> Swelling of ankles	<input type="checkbox"/> Sore that won't heal	
	<input type="checkbox"/> Varicose veins		

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

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

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

(All information is strictly confidential)

<b>FAMILY HISTORY</b> Fill in health information about your family.							
Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relative had any of the following:		
					Disease	Relationship to you	
Father					Arthritis		
Mother					Asthma, Hay Fever		
Brothers					Cancer		
					Chemical Dependency		
					Diabetes		
					Heart Disease, Strokes		
Sisters					High Blood Pressure		
					Kidney Disease		
					Tuberculosis		
					Other		

  

HOSPITALIZATIONS				PREGNANCY HISTORY		
Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Sex of Birth	Complications if any	

  

Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give approximate dates. _____	<b>HEALTH HABITS</b> Check (✓) which substances you use and describe how much you use.																																							
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">SERIOUS ILLNESS/INJURIES</th> <th style="width: 10%;">DATE</th> <th style="width: 20%;">OUTCOME</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	SERIOUS ILLNESS/INJURIES	DATE	OUTCOME																			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"> </td> <td style="width: 10%;">Caffeine</td> <td style="width: 80%;"> </td> </tr> <tr> <td> </td> <td>Tobacco</td> <td> </td> </tr> <tr> <td> </td> <td>Drugs</td> <td> </td> </tr> <tr> <td> </td> <td>Other</td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>		Caffeine			Tobacco			Drugs			Other							
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IMMUNIZATIONS				OCCUPATIONAL CONCERNS	
				Check (✓) if your work exposes you to the following:	
Tetanus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumovax	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Flu Vaccine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	TB Screening	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Childhood Imm.	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date