Health History Form

Legal Last Name: Legal First Name:	Gender Identity: ☐Man ☐Woman ☐Transgender ☐Genderqueer Sex assigned at birth: ☐Male ☐Female	ID#:
Preferred Name:	Email Address:	
Preferred Pronoun:		
Local Address *(include city, state & zip)*:	Cell Phone:	
	Cell Phone Carrier:	
Birth Date:	**Current Prescribed Medications** *(list all including birth control)*	

ALLERGIES	**What is reaction?**	**Medication/Dosage**	**Reason**

HOSPITALIZATIONS/SURGERY *(List All)*		**Current Herbal/Vitamins or Non-Prescribed Medications**	
Year	**Reason:**	**Medication**	**Dosage** *(if known)*

Whom do you want notified in case of an emergency?

Name: Relationship:

Home Phone: Work Phone: Cell Phone:

Health - Smoking	Y	N
Do you smoke cigarettes?		
Use smokeless tobacco?		
If yes, how many/day?		
# of Quit Attempts:		
Do you want to quit?		
# of years you've smoked		

Health – Alcohol	Y	N
Do you drink alcohol?		
Have you felt a need to cut down?		
If yes, how many drinks per week?		

Health – Street Drugs	Y	N
Do you use street drugs?		
If yes, what type?		
If yes, how often?		

Health - Other	Y	N
Do you exercise regularly?		
If yes, how often and type?		
Do you use seat belts regularly?		

Any questions or concerns regarding any of the following:	Y	N		Y	N
Family alcoholism or drug abuse?			Your appearance, weight or nutrition?		
Rape, sexual abuse or unwanted sexual activity?			Dating/Domestic violence or stalking?		

During the past month, have you felt sad, lonely, down, depressed or hopeless?	Frequently	Rarely	Never
During the past month, have you felt little interest or pleasure in doing things?	Frequently	Rarely	Never

Core Family Health History	**Mom**	**Dad**	**Sibling**	**Core Family Health History**	**Mom**	**Dad**	**Sibling**
Alcoholism				High blood pressure			
Drug abuse				High cholesterol			
Blood or clotting disorder				Cancer/type:			
Depression/psychiatric illness							
Diabetes				Hereditary disease/type:			
Stroke				Tuberculosis			
Heart disease				Sudden unexpected Death before age 50			
Thyroid Problems				Other serious illness/type:			

Personal History **Have you had or do you now have:**

Head/Neurologic	Past	Present	**Heart/Circulation/Chest**	Past	Present	**Genitourinary**	Past	Present
Headaches- occasional			Severe chest pain/pressure			Urinary/kidney Problem		
Migraine:			Heart disease or murmur			Frequent Bladder Infection		
Circle: Rare			Rapid or irregular pulse			**Chronic Diseases**		
Occasional			Blood clots/vein problems			Diabetes		
Frequent			**Respiratory**			Asthma		
Dizziness or fainting			Chronic cough > 1 month			High blood pressure		
Loss of consciousness			Pneumonia			Arthritis		
Head injuries/concussion			Tuberculosis or + test			Sickle cell disease		

	Past	Present		Past	Present		past	Present
Eyes			Shortness of breath			Seizures or Epilepsy		
Vision or eye problems			**Gastrointestinal**			Thyroid Disease		
Glasses/contact lenses			Abdominal pain (severe/recurrent)			Elevated Cholesterol		
Last eye exam (year):						Obesity		
Ears/Nose/Throat			Heartburn			**Psychiatric**		
Allergies or hay fever			Ulcer			Anxiety		
Ear or hearing problems			Hepatitis			Depression		
Frequent sinusitis			Stomach/Bowel movement problems			Bipolar		
Dental problems						Other mental health concerns		
Last dental exam (year):			Gallbladder disease			**Additional Medical History**		
Skin			Hernia			ADD/Learning disability		
Severe acne or skin disorder			**Musculoskeletal**			Cancer		
New or changing moles			Swollen or painful joints or extremities			Eating Disorder		
Blood Disorder						Unusual Fatigue > 1 month		
Anemia			Chronic or severe back problems			Recent gain or loss of weight > 10 pounds		
Bleeding disorder								
Enlargement of glands or lymph nodes			**Other**			**Other**		

Sexual Health ***If N/A, skip to next section***

If sexually active how long have you been sexually active?		Anal Oral Vaginal ***(circle)***		Last sexual encounter:
Number of lifetime partners:		Number of months with current partner:		Have your sexual partners been: *(circle)* Male Female Both Intersex
Have you ever had an STD?	Y N	Last STD screen (m/d/y)		HPV Vaccine 1 2 3 None (*circle*)

If yes, circle all that apply: Chlamydia Gonorrhea HPV/Genital Warts Genital Herpes HIV Other:

Are you presently using a method of birth control: *(circle)* Pill Ring Depo Plan B Condom None Other:

Are you aware that emergency contraception (morning after pill) is available for females? Y N

Women's Health

	Y	N		
Do you have monthly periods?			Last Period: (m/d/y)	
Date of last pap m/d/y			Pap was: abnormal normal *circle one*	
Have you had any special procedures because of an abnormal pap? Explain.				
Have you ever been pregnant?			If yes, when? (m/d/y)	
Complications? If yes, explain.				

\# of live births ___ # of miscarriages ___ # of terminations ___

Have you ever had or do you now have:	past	present
Breast lumps or discharge		
Vaginal infections or abnormal discharge		
Pain or bleeding with intercourse or outercourse		
Ovarian cysts or endometriosis		
Have you had education about breast self- examination (BSE)?		

Men's Health

	past	present		past	present
Do you have any penile discharge or change in urination?			Have you ever had undescended testicles, testicular problems or cancer?		
Have you ever had prostate problems?			Do you regularly examine your testicles for swelling or lumps?		

Transgender Health

Hormone Therapy			Male to Female Procedures		
Female to Male Procedures					

Patient Signature:	**Date:**
Provider Signature/comments:	**Date:**