ResourceCare COMMUNITY HEALTH CENTER

HEALTH HISTORY
18 YEARS AND OLDER

DOB _____ Age _____ Today's Date _____

Chief complaint today? _____

_____

_____

Are you in good health? ____Yes ____ No Date of last physical exam: _____

Have there been any changes in your general health within the past year? ____ Yes ____ No

Previous Physician's Name: _____ Physician's Telephone: _____

Physician's Address: _____

Past Medical History– List any history that has been *diagnosed* by a doctor Does not apply to me _____

	Anxiety		Diabetes– Non Insulin		Hypothyroid
	Arthritis		Dialysis		Hyperthyroid
	Asthma		Diverticulitis		Kidney disease
	Acid reflux		Fibromyalgia		Kidney stones
	Autoimmune disease		Gout		Leg/foot ulcers
	Birth defects		Heart Attack		Liver disease
	Cancer– If yes, what kind?		Heart murmur		Osteoporosis
	_____		Hepatitis– If yes, what kind? _____		Pacemaker
	COPD		Hiatal Hernia		Stomach ulcers
	Coronary artery disease		HIV or AIDS		Seizures
	Depression		High cholesterol		Stroke
	Diabetes– Insulin		High blood pressure		Other _____

Medications– List all prescribed and over the counter medications Does not apply to me (initials) ____

	Drug Name	Strength	Frequency Taken
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

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Preferred Pharmacy (list only one) _____

Allergies– Please list medication, food and environmental allergies Does not apply to me (initials)_____

	Allergy	Reaction
1		
2		
3		

Past Surgical/Hospitalization History

Does not apply to me (initials) ____

	Reason	Year	Hospital
1			
2			
3			
4			

Specialist– List any specialist that you are under the care of Does not apply to me (initials) ____

	Doctor	Type	City/State	Reason
1				
2				
3				

Family Health History

Does not apply to me (initials) ____

	Father	Mother	Brother	Sister	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal
Alive and Well								
Health History Unknown								
Alcoholism								
Cancer (Type) **B**reast **L**ung **Pa**ncreatic **Pr**ostate **L**iver **K**idney **C**ervical **O**ther								
Diabetes Insulin (DI) Diabetes Non-Insulin (DN)								
Heart Attack								
High Blood Pressure								

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Immunization History

Does not apply to me (initials) ____

	Date
Flu	
Pneumonia	
Tdap	
Shingles	

Social History

Does not apply to me (initials) ____

Marital Status (Circle one)	Single Married Divorced Separated Widowed Domestic Partner
Children / Siblings	# of sons living ___/deceased___ # of daughters living ___/deceased ___ # of brother living ___/deceased ___ # of sisters living/deceased ___
Lives with (Circle one)	Alone Parent Spouse Partner Brother Sister Mother Father Grandparent Other
Education (Circle one)	None Elementary SomeHS GED HSgraduate SomeCollege PTstudent FTstudent TradeSchool CollegeGraduate PostGrad

Employment

Does not apply to me (initials) ____

Full Time Part Time Disabled on disability Disabled no disability Retired Stay at home parent Student Unemployed
Occupation:
Do you think that your health problems are related to your surrounding? YES or NO
If yes, are your problems worse at Home or Work?
Are you exposed to any chemicals? YES or NO If yes, list chemicals

Sex

Does not apply to me (initials) ____

Sexual activity (Circle one)	Current Previous Never
# of partners in the past year	
# of partners during lifetime	

	I have never had an STI
	Yes, currently/previously had a STI What kind?
	I have never been tested for STI's or HIV
	I have been tested for STI's including HIV

Stressors

Does not apply to me (initials) ____

	None		Health problems
	Financial		Physical condition
	Marital		Family situation
	Family		Living situation
	Estranged from family		Job situation
	Emotional state		Sexual orientation

Misc

Does not apply to me (initials) ____

I Exercise _____ times per week

I have caffeine _____ times per week

Sun Exposure (circle one) Frequently Occasionally Rarely

Seatbelt Use (circle one) 100% 75% 50% 25% 0%

Helmet Use (circle one) 100% 75% 50% 25% 0%

Tobacco

Does not apply to me (initials) ____

Do you use Tobacco? YES or No	Cigarettes packs per day?
Have you ever used in the past? YES or No	Chewing tobacco per day?
Age started?	Cigars per day?

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Alcohol

Does not apply to me (initials) ____

Do you drink alcohol? YES NO Previously	How often? Daily Weekly Monthly Occasionally
Avg # of drinks per week?	What kind? Beer Wine Liquor

Drug Use/HIV Risk

Does not apply to me (initials) ____

Drug use: Current Previous Never
If yes, which drugs used?
Method of use?
Frequency of use?
HIV High Risk Behavior (needle sharing, unprotected sex, same sex) YES NO If yes, list _____

Preventative Care: Please list the most recent dates

Does not apply to me (initials) ____

Test	Date	Doctor
Eye Exam		
Colonoscopy		

OB and GYN History

Does not apply to me (initials) ____

Last PAP Smear date		Provider?	Abnormal? YES or NO
Last Mammo date		Where at?	Abnormal? YES or NO
Age of First Menstrual Period?		Last Period?	
Age of Menopause?		Contraception? YES or NO If yes, kind?	
Hysterectomy? Partial or Total		# of pregnancies?	
# of Miscarriages?		OBGYN Provider:	

_____ _____

Patient, Parent or Guardian Signature Date

Health History Reviewed by (staff name) _____ Date _____