FAMILY FIRST HEALTHCARE

General Health History Form

TODAY'S DATE:_____

Legal name (Last, First, MI):_____ DOB: _____
Preferred name (if different): _____ MRN: _____
Sex assigned at birth: □ Male □ Female □ Other
Reason for visit today: _____

MEDICATIONS: List all current medications (dose and frequency): List all current supplements:

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____
4. _____ 4. _____
5. _____ 5. _____

ALLERGIES: List drug allergies and reactions:

1. _____
2. _____
3. _____

List any food, insect or latex allergies and reactions:

1. _____
2. _____
3. _____

HEALTH MAINTENANCE SCREENING TEST HISTORY:

TEST:	DATE:	FACILITY/PROVIDER:	ABNORMAL RESULTS:
COLONOSCOPY			No Yes
MAMMOGRAM			No Yes
PAP SMEAR			No Yes
BONE DENSITY			No Yes

VACCINATION HISTORY:
Last Flu vaccine? _____
Last Pneumovax (*Pneumonia*): _____
Last Prevnar vaccine: _____
Last Zoster vaccine (*Shingles):* _____

IMMUNIZATIONS:
Tdap (booster received within 10 yrs?): □ No □ Yes □ Not sure
Last Tetanus Booster or TdaP? _____
HPV (completed 3 shots?): □ No □ Yes □ Series started □ Not sure

SOCIAL HISTORY:
Occupation (or prior occupation): _____ □ Retired □ Unemployed □ LOA □ Disabled
Employer: _____
Marital Status: □ Single □ Partner □ Married □ Divorced □ Widowed □ Other: _____
Do you have children? □ No □ Yes If yes, how many? _____

OTHER HEALTH ISSUES:
Do you drink alcohol? □ No □ Yes
How many times a week? _____
How many drinks per sitting? _____
History of alcohol abuse? □ No □ Yes
Do you use drugs? □ No □ Yes

Do you use tobacco or nicotine products? □ No □ Yes
(type): □ cigarettes □ cigars □ e-cigs (JUUL) □ smokeless tobacco
How many per day? _____
Frequency of use? □ daily □ weekly □ monthly □ rarely
For how long? _____

(type of drugs): _____ Past history of smoking? □ No □ Yes Date quit:_____

SEXUAL ACTIVITY:
Sexually involved currently? □ Yes □ No (*If no sexual history, please continue to Exercise)*
Sexual partner(s) is/are/have been: □ Male □ Female
Birth control method: □ None □ Condom □ Pill/Ring/Patch/Inj/IUD □ Vasectomy

EXERCISE:
Do you exercise? □ No □ Yes Any limiting factors?_____
Activity? _____ How often? _____
Duration (minutes per session): □ <15 □ 15-30 □ 30-45 □ 45-60 □ >60

SLEEP:
How many hours, on average, do you sleep at night (*or during the day, if working night shift?)* _____

DIET:
How would you rate your diet? □ Good □ Fair □ Poor

SAFETY:
Do you use seat belts consistently? □ Yes □ No Working smoke detector in home? □ Yes □ No
If you have guns at home, are they locked up? □ Yes □ No
Is violence at home a concern for you? □ Yes □ No
Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? □ Yes □ No

MEDICAL CONDITIONS: current and past

	No	Yes		No	Yes
ADHD			High cholesterol		
Alcoholism/Drug Abuse			Kidney disease		
Asthma			Liver disease, hepatitis or tumor		
Blood Clots			Lupus		
Bleeding disorder			Migraine headache: □ without aura □ with aura		
Cancer: type _____			Rheumatoid/Juvenile rheumatoid arthritis		
Depression/Anxiety/Bipolar/Suicidal			Seizures		
Diabetes: □ Type 1 □ Type 2			Thyroid disease		
Eating disorder			Tuberculosis		
Emphysema *(COPD)*			UTI (frequent)		
Heart disease or condition			Stroke or stroke like problems		
High blood pressure			Other: _____		

SURGICAL HISTORY:

	Yes	Date		Yes	Date
Appendectomy (Appendix)			Hemorrhoidectomy		
Breast Biopsy			Hysterectomy		
Carotid endarterectomy			Hysteroscopy		
Cataract surgery			Inguinal hernia repair		
Cesarean section (C-section)			Low back pain surgery		
Cholecystectomy (Gall Bladder)			Mastectomy (Breast removal)		
Coronary artery bypass			Partial colectomy (Part of colon)		
Debridement of wound, burn, or infection			Prostatectomy		
Dilation & curettage (D&C)			Tonsillectomy		
Free skin graft					

FAMILY HISTORY: Do you have a parent, sibling or grandparent with a history of the following?

	No	Yes	Which relative?	Age at diagnosis
Alcohol/Drug Abuse				
Asthma				
Blood clot or other clotting disorder (DVT, PE)				
Breast cancer				
Cancer: type(s): _____				
Depression/Anxiety/Bipolar/Suicidal				
Diabetes				
Early Death				
Emphysema (COPD)				
Heart attack, angina				
High blood pressure				
High cholesterol				
Kidney disease				
Migraines				
Thyroid disease				
Stroke				
Other				
Other				
Other				
Other				

REVIEW OF SYSTEMS: Please indicate any current symptoms (within past three months)

GENERAL	□ Fatigue □ Chills □ Night sweats □ Fever □ Weight gain □ Weight loss
SKIN	□ Rash □ New or changing moles □ Excessive hair on skin □ Bumps or sores on skin
EYES	□ Redness □ Vision changes □ Itchy eyes □ Light sensitivity □ Eye pain □ Eye discharge
EAR, NOSE, THROAT	□ Hearing loss □ Ringing in ears □ Trouble swallowing □ Nasal congestion/drainage
RESPIRATORY	□ Cough □ Wheezing □ Shortness of breath
CARDIOVASCULAR	□ Chest pain □ Leg swelling □ Irregular heartbeat
BREAST	□ Nipple discharge □ Breast pain □ Lumps
NEUROLOGICAL	□ Dizziness □ Fainting □ Headache □ Numbness □ Tingling □ Tremors □ Weakness □ Seizures □ Trouble walking or falls □ Memory loss
MENTAL HEALTH	□ Anxiety □ Depressed mood/Low mood □ Self harming/cutting □ Suicidal thoughts □ Thoughts of harming others □ Hallucinations □ Paranoia □ Sleep problems
ENDOCRINE	□ Cold intolerance □ Heat intolerance □ Excessive thirst □ Hot flashes
MUSCULOSKELETAL	□ Muscle aches □ Joint stiffness □ Joint pain □ Joint swelling □ Neck pain □ Back pain
HEMATOLOGIC	□ Easy bleeding □ Easy bruising □ Swollen lymph nodes □ Blood clots
GASTROINTESTINAL	□ Abdominal pain □ Heartburn □ Constipation □ Diarrhea □ Nausea □ Vomiting □ Blood in stool □ Loss of appetite
GENITOURINARY	□ Pain or burning on urination □ Frequent urination □ Leakage of urine □ Weak urinary stream □ Awakening at night to urinate more than once □ Blood in urine □ Decreased sexual desire □ Pain with sex □ Problems with orgasm □ Genital sore/rash/itching □ Problems with erection □ Penile discharge □ Testicular discomfort □ Vaginal dryness □ Unusual vaginal discharge

SEXUAL/RELATIONSHIP HISTORY:

Do you have sex with: □ Men □ Women □ Both □ Not applicable

What do you use for birth control (if applicable): □ Birth control pills □ Condoms/Dams □ IUD □ Withdrawal method
□ Nexplanon/Implanon □ Nuvaring □ Depo-Provera □ Diaphragm
□ Tubal ligation □ Vasectomy □ Nothing

History of sexually transmitted infections (STI)? □ No □ Yes □ Never tested □ Not applicable

When was your last STI screening? _____ □ Never tested □ Don't know □ Not applicable

Do you wish to be screened for STI today? □ No □ Yes □ Not applicable

Have you had new sexual contact(s) since last STI screening? □ No □ Yes □ Not applicable

Have you been physically hurt by your partner or ex-partner? □ No □ Yes

Have you been emotionally abused by your partner or ex-partner? □ No □ Yes

Have you had unwanted sexual activity as a child or as an adult? □ No □ Yes

GYNECOLOGIC HISTORY (if applicable):

Age at first period: _____ First day of your last menstrual period: _____

Regular periods? □ No □ Yes Do you have bleeding between your periods? □ No □ Yes

Period comes every how many days? _____ Period usually lasts how many days? _____

Menstrual cramps: □ None □ Mild □ Moderate □ Severe

Menstrual flow: □ Light □ Moderate □ Heavy

PAP HISTORY (if applicable):

Date of last PAP _____ □ Normal □ Abnormal (result): _____

Have you ever had an abnormal PAP? □ No □ Yes (date): _____

Have you ever had colposcopy? □ No □ Yes (date): _____

Have you ever had LEEP? □ No □ Yes (date):_____

PREGNANCY HISTORY (if applicable):

Currently pregnant? □ No □ Yes

Currently breastfeeding? □ No □ Yes

Pregnancy outcomes: □ Birth #_____ □ Abortion # _____ □ Miscarriage #_____ □ Ectopic pregnancies # _____

Complications or comments: _____

OTHER PROVIDERS/SPECIALISTS:

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other: _____		
Other: _____		

ADDITIONAL INFORMATION:

Have you traveled outside of the country in the last 30 days? □ Yes □ No

If yes, where? _____

Have you served in the military? □ Yes □ No If yes, how long and what branch? _____

Were you deployed? □ Yes □ No If yes, where? _____