NORTHEAST HEALTH DISTRICT • HEALTH HISTORY FORM

PATIENT LABEL HERE **DATE**_____

Allergies:

MEDICATION ALLERGIES (please list):_____

OTHER : ☐Latex ☐Adhesive tape ☐ Iodine ☐ Food ☐ Other_____

Family Medical History:

Please check if any members of your IMMEDIATE FAMILY (mother, father, sister, brother, children, grandparents) have presently or had in the past any of the conditions listed below:

CONDITION	YES	NO	FAMILY MEMBER	CONDITION	YES	NO	FAMILY MEMBER
High blood pressure				Cancer			
Stroke				Smoking			
Kidney				Birth defects			
Blood disorders				Family Violence or Abuse			
Diabetes				Depression, Bipolar, Schizophrenia			
Thyroid problem				Alcohol Abuse			
Heart attack or heart disease				Drug abuse			

YOUR Personal History:

Please complete the following: (Mark an X in the appropriate box.)

CONDITION	YES	NO	COMMENTS (For Staff use only)
1.Hospitalizations/Surgery/Injuries			
2. Childhood diseases			
3. Chickenpox			
4. Tuberculosis/positive TB skin/blood test			
5. Hepatitis/ liver infection/mono			
6. Head/severe headaches			
7. Vision problems/blindness			
8. Ear infections/Hearing loss			
9. Dental problems			
10. Throat/sinus			
11. Heart problems/chest pain			
12. High blood pressure			
13. Lung disease/asthma/emphysema			
14. Stomach or digestive			
15. Kidney/bladder/prostate			
16. Sexually transmitted infections			
17. Phlebitis/varicose veins			
18. Arthritis/back problems/weak bones			
19. Anemia / abnormal blood clotting			
20. Cancer			
21. Diabetes			
22. Thyroid			

CONDITION	Yes	No	Comments: (Staff use only)
23. Seizures/Stroke			
24. Depression/Anxiety			
25. Bipolar/schizophrenia			
26. Abuse (physical or sexual)			
27. Do you take any medications?			
28. Use any form of tobacco?			
29. Drink alcohol?			
30. Use street drugs?			
31. Exercise regularly?			
32. Use seat belts or car seats in the car?			
33. Does your job involve anything that might be dangerous to you?			
34. Are you currently sexually active?			
35. Any sexual problems?			
36. Are you using birth control?			
37. Problems with birth control?			
38. HIV			

Age at 1st sexual intercourse_____ # of partners in last 6 months_____ # of partners in lifetime_____

For Women Only:

Age that you first started having a period_____
Are your periods regular?_____

How often do you have periods?_____

How long do they last?_____days

Is the bleeding: light / moderate / heavy (circle one)

Cramping? Mild / moderate / severe (circle one)

Have you stopped having periods?_____

If yes, when?_____

Number of pregnancies_____Number of children _____

Number of miscarriages_____abortion(s)_____

Pregnancy complications?_____

If you were born before 1971, did your mother ever take a medication called DES? _____

When was your last pap smear? _____

Was it normal? _____

Have you ever had a mammogram? _____

If yes, when was the last one?_____Was it normal?____

Have you ever had any of the following?

Abnormal pap smear? _____

Female surgery/ procedure (Cryo, LEEP, etc.?)
_____

Female problems without surgery (cysts, fibroids)? _____

Breast problems (lumps, discharge, cysts, etc)? _____

Staff Comments:_____

Anything else about you that I need to know? _____

Patient Signature: _____ Date: _____

Reviewed by:	***Date:***
Updated by:	***Date:***
Updated by:	***Date:***
Updated by:	***Date:***
Updated by:	***Date:***