GENERATIONSPAN HEALTHCARE

HEALTH HISTORY FORM

Date: _____

Name: _____ DOB: _____ SSN:_____

Ethnicity/Race:_____ Gender: Male/Female (Circle)

Language: (list all)_____

Address:

Street/PO Box	**City/State**	**Zip**

Emergency Contact Name:_____ Phone:_____

Previous Provider:_____ Last Physical Exam:_____

Last Emergency Room Visit or Urgent Care Visit:_____

Pharmacy Name:_____ Location or Phone:_____

Chief Complaint, Why are you here? _____

How long have you had this problem?_____

Do you need refills today? Yes/No (Circle)

Have you taken any medications today? Yes/No (Circle)

Please list all allergies:_____

Do you Smoke/Tobacco? Yes/No (Circle) When did you start? _____

How long?_____ Do you want to quit?_____

Alcohol/Drug Use? Yes/No (Circle) CAGE? Have you received treatment? Yes/No (Circle)

Are you a victim of rape, domestic abuse, etc.? Yes/No (Circle)

Have you received treatment? Yes/No (Circle)

Are you currently in treatment? Yes/No (Circle)

Past Medical History

Please select all that apply:

	Yes or No:			Yes or No:	
Hypertension	☐	☐	Bladder problem	☐	☐
Diabetes	☐	☐	Prostate Disease	☐	☐
Cholesterol	☐	☐	CVA/Stroke	☐	☐
Kidney disease	☐	☐	Migraines	☐	☐
Stomach Ulcer	☐	☐	Leukemia	☐	☐
Pneumonia	☐	☐	Lupus	☐	☐
COPD	☐	☐	Sickle Cell	☐	☐
Asthma	☐	☐	Murmur	☐	☐
Emphysema	☐	☐	Skin Cancer	☐	☐
Loss of Hearing	☐	☐	Depression	☐	☐
Blindness	☐	☐	Anxiety	☐	☐
Memory Problem	☐	☐	Bipolar	☐	☐
Seizure	☐	☐	Schizophrenia	☐	☐
Cancer	☐	☐	Suicide Attempts	☐	☐
HIV/AIDS	☐	☐	Hepatitis	☐	☐
GERD	☐	☐	Other:		
Syphilis	☐	☐			

List all medications:_____

_____

_____

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Surgical History

Gall bladder	Yes ☐	No ☐	Date:_____
Total Hysterectomy	Yes ☐	No ☐	Date:_____
Partial Hysterectomy	Yes ☐	No ☐	Date:_____
Laminectomy	Yes ☐	No ☐	Date:_____
Disectomy	Yes ☐	No ☐	Date:_____
Knee surgery	Yes ☐	No ☐	Date:_____
Back Surgery	Yes ☐	No ☐	Date:_____
Nose Surgery	Yes ☐	No ☐	Date:_____
Skin Cancer Surgery	Yes ☐	No ☐	Date:_____
Brain Surgery	Yes ☐	No ☐	Date:_____
Thyroid Removal	Yes ☐	No ☐	Date:_____
Gastric bypass	Yes ☐	No ☐	Date:_____
Lap Band	Yes ☐	No ☐	Date:_____
Hemorrhoid	Yes ☐	No ☐	Date:_____
CABAG (Op. Hrt Surg)	Yes ☐	No ☐	Date:_____
Eye surgery	Yes ☐	No ☐	Date:_____
Bladder Surgery	Yes ☐	No ☐	Date:_____

Other:

_____

_____

Number of Pregnancies:_____How many alive?_____Number of Sexual Partners?: _____

Are you using contraceptives? Yes/No (Circle) Type? _____

Do you have sex with: Male/Female or both?

Female: When was your last menstrual period? _____

Immunizations: Check all that apply

Tetanus Yes ☐ No ☐	Pertussis: Yes ☐ No ☐	Hep B: Yes ☐ No ☐	Varicella: Yes ☐ No ☐
Diptheria: Yes ☐ No ☐	Polio: Yes ☐ No ☐	Measels: Yes ☐ No ☐	Rubella: Yes ☐ No ☐
Mumps: Yes ☐ No ☐	Influenza: Yes ☐ No ☐	Pneumo: Yes ☐ No ☐	

Screenings: Check all that apply

Tuberculosis Skin Test: Yes ☐ No ☐	Pap smear: Yes ☐ No ☐
Mammograms: Yes ☐ No ☐	Stool Test for Occult Blood: Yes ☐ No ☐

Cholesterol Test: Yes ☐ No ☐

Family History

Please place the number(s) of your family members next to the condition that applies:

1. Children
2. Siblings
3. Grandmother on father's side
4. Grandmother on mother's side
5. Grandfather on father's side
6. Grandfather on mother's side
7. Aunt
8. Uncle
9. Grandchildren

History	Family
Hypertension	
Coronary Artery Disease	
Cholesterol	
Stroke	
Diabetes	
Thyroids	
Renal Disease	
Arthritis	
Tuberculosis	
Asthma	
Lung Disease	
Headache	
Seizure	
Mental Illness	
Substance Abuse	
Ovarian Cancer	
Colon Cancer	
Prostate Cancer	
Sickle Cell	
Other:	

Comprehensive Review of System

Circle only what applies:

Skin: rash, sores, itching, dryness, color changes, changes in hair or nails, moles

Head, Eyes, Ear, Nose, Throat (HEENT): headache, dizziness, lightheaded, eye pain, redness, vision impaired, excessive tearing, blurred, spots, glaucoma, cataracts, hearing loss, ringing in ear, vertigo, earaches, hearing loss, discharge, nasal congestion, discharge, nosebleed, gum pain, bleeding gums, dentures.

Last dental exam_____

Last eye exam_____

Neck: swollen gland: goiter, lumps, pain, or stiffness

Breast: lump, pain, discharge, self-exam practice Last Mammography:_____

Respiratory: coughing, wheezing, hemoptysis, dyspnea, asthma, bronchitis, emphysema, pneumonia

Last Chest X-ray_____

Cardiovascular: heart trouble, high blood pressure, heart murmur, chest pain or discomfort, palpitations, dyspnea, orthopnea, paroxysmal nocturnal dyspnea, edema,

Past ECG or cardiac test _____

Gastrointestinal: trouble swallowing, heartburn, appetite, nausea, bowel irregularity, change in bowel habit, pain with defecation, rectal bleeding, or black tarry stools, hemorrhoids, constipation, diarrhea, abdominal pain, excessive belching or passing gas

Last colonoscopy_____

Peripheral vascular: leg cramps, varicose veins, past clots in the veins, swelling in calves or feet, color changes in fingers or toes during cold weather, swelling with redness or tenderness

Urinary: frequent urination, thirsty, or hungry all the time, frequent urination at night, urgency, burning or pain during urination, hematuria, kidney stone, blood in the urine, incontinent, dripping, reduce force, hesitancy

Genitalia: penile or vaginal discharge, vaginal or penile rash, swelling scrotum

STDS: menopause symptoms, age at menopause, bleeding after menopause, vaginal itching, sores, lumps, sexual dissatisfaction

Musculoskeletal: muscle weakness, pain, stiffness, back-ache, neck or back pain, fever, chills, rash, weight loss, weakness, anorexia

Neurological: changes in mood, attention, speech, headache, dizziness, vertigo, fainting, blackouts, seizures, weakness, numbness, paralysis, tingling or "pins and needles", tremors or other involuntary movements

Hematological: anemia, bruising, bleeding, past transfusions, transfusion reactions