

# WHCC Health History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Your Primary Care Provider (if known) is: \_\_\_\_\_

What is the main reason for, or goal of, today's visit? \_\_\_\_\_

List other health concerns, or questions you have (These may need to be covered at a future visit): \_\_\_\_\_

Are you allergic to any medications?  Yes  No

Drug Name

Type of Reaction

## Surgeries, Hospitalizations, Injuries

List all major injuries, surgeries, and hospitalizations:

Surgery/Hospitalization/Injury	Date Date of Diagnosis	Hospital or Treating Physician

## Past Health History

In the PAST, have you had any problems with the following? Please check one box for each item:

YES	NO	Describe	YES	NO	Describe
<input type="checkbox"/>	<input type="checkbox"/>	Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>	Bladder or kidney:
<input type="checkbox"/>	<input type="checkbox"/>	Blood Sugar:	<input type="checkbox"/>	<input type="checkbox"/>	Uterus or ovaries:
<input type="checkbox"/>	<input type="checkbox"/>	Anemia:	<input type="checkbox"/>	<input type="checkbox"/>	Stomach:
<input type="checkbox"/>	<input type="checkbox"/>	Eyes or vision:	<input type="checkbox"/>	<input type="checkbox"/>	Colon/Bowel:
<input type="checkbox"/>	<input type="checkbox"/>	Ears or hearing:	<input type="checkbox"/>	<input type="checkbox"/>	Skin disease:
<input type="checkbox"/>	<input type="checkbox"/>	Nose or Sinuses:	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis:
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid gland:	<input type="checkbox"/>	<input type="checkbox"/>	Depression or Anxiety:
<input type="checkbox"/>	<input type="checkbox"/>	Heart:	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia or Bulimia:
<input type="checkbox"/>	<input type="checkbox"/>	Lungs/Breathing:	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or Drugs:
<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gallbladder:	<input type="checkbox"/>	<input type="checkbox"/>	DES exposure:
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis:	<input type="checkbox"/>	<input type="checkbox"/>	Allergies:

Other major health problems: \_\_\_\_\_


PT.NO \_\_\_\_\_

NAME \_\_\_\_\_

DOB \_\_\_\_\_

**UW Medicine**  
 Harborview Medical Center – UW Medical Center  
 Northwest Hospital & Medical Center – University of Washington Physicians  
 Seattle, Washington

**WHCC HEALTH HISTORY**  
**PAGE 1 OF 6**



\*U2665\*

UH2665 REV JAN 13

WHCC Health History continued

**Personal/Social History**

Current Occupation: \_\_\_\_\_

Country born in: \_\_\_\_\_

Where and with whom do you live? \_\_\_\_\_

Do you have any trouble taking care of your daily activities (e.g. buying food, arranging transportation)?  Yes  No

Are you under particular stresses?  Yes  No

Do you have help with transportation if needed?  Yes  No

**Symptom Review**

For each item below, show whether you have had any recent problems by checking "Yes" or "No:"

<b>General:</b> Weight change without trying <input type="checkbox"/> Yes <input type="checkbox"/> No Unusual fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No Fevers <input type="checkbox"/> Yes <input type="checkbox"/> No Loss of appetite <input type="checkbox"/> Yes <input type="checkbox"/> No Awakening due to pain <input type="checkbox"/> Yes <input type="checkbox"/> No Feeling full quickly <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Intestinal:</b> Blood in stool <input type="checkbox"/> Yes <input type="checkbox"/> No Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No Abdominal pain <input type="checkbox"/> Yes <input type="checkbox"/> No Abdominal bloating <input type="checkbox"/> Yes <input type="checkbox"/> No Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Neurologic/psychiatric:</b> Loss of memory <input type="checkbox"/> Yes <input type="checkbox"/> No Weakness in limbs <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness or passing out <input type="checkbox"/> Yes <input type="checkbox"/> No Numbness or tingling <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Head/eye/ears/throat:</b> Changes in your eyesight <input type="checkbox"/> Yes <input type="checkbox"/> No Hoarse voice <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty hearing <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Blood/growths:</b> Bleeding from gums <input type="checkbox"/> Yes <input type="checkbox"/> No Swollen lymph nodes <input type="checkbox"/> Yes <input type="checkbox"/> No Breast lump or pain <input type="checkbox"/> Yes <input type="checkbox"/> No Lump or mass elsewhere <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Joints, bones and muscles:</b> Muscle or bone pain <input type="checkbox"/> Yes <input type="checkbox"/> No Painful joints <input type="checkbox"/> Yes <input type="checkbox"/> No Swollen ankles <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Heart:</b> Palpitation <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Skin:</b> Non-healing sores(s) <input type="checkbox"/> Yes <input type="checkbox"/> No Changing moles(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Glands/endocrine:</b> Thirsty all of the time <input type="checkbox"/> Yes <input type="checkbox"/> No Can't stand heat or cold <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Lungs:</b> Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No Cough <input type="checkbox"/> Yes <input type="checkbox"/> No Coughing up blood <input type="checkbox"/> Yes <input type="checkbox"/> No Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Gynecologic/urinary:</b> Pelvic pain <input type="checkbox"/> Yes <input type="checkbox"/> No Irregular or heavy periods <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding after menopause <input type="checkbox"/> Yes <input type="checkbox"/> No Blood in urine <input type="checkbox"/> Yes <input type="checkbox"/> No Pain with intercourse <input type="checkbox"/> Yes <input type="checkbox"/> No Unusual vaginal discharge <input type="checkbox"/> Yes <input type="checkbox"/> No Discharge color: _____	Do you have any other health concerns that your provider should know about today? If yes, please explain: _____ _____ _____ _____

How would you rate your general Health?  Excellent  Good  Fair  Poor

During the past month, has feeling down bothered you, feeling depressed or hopeless?  Yes  No

During the past month, have you been bothered by little interest or pleasure in doing things?  Yes  No

Over the last 2 weeks, have you been bothered by feeling nervous, anxious, or on edge?  Yes  No

Over the last 2 weeks, have you been bothered by not being able to stop or control worrying?  Yes  No

PT.NO


NAME

DOB

Place EPIC Label Within Box

**UW Medicine**  
 Harborview Medical Center – UW Medical Center  
 Northwest Hospital & Medical Center – University of Washington Physicians  
 Seattle, Washington

**WHCC HEALTH HISTORY**  
**PAGE 2 OF 6**



\*U2665\*

UH2665 REV JAN 13

### Family History

Has anyone in your immediate or extended family had:  
If "Yes" indicate RELATIONSHIP and AGE at the time of diagnosis.

YES	NO		RELATIONSHIP	AGE	YES	NO		RELATIONSHIP	AGE
<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer			<input type="checkbox"/>	<input type="checkbox"/>	Diabetes		
<input type="checkbox"/>	<input type="checkbox"/>	Ovarian Cancer			<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease		
<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer			<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure		
<input type="checkbox"/>	<input type="checkbox"/>	Other Cancers			<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis		
<input type="checkbox"/>	<input type="checkbox"/>	Other Illnesses			What: _____				

### Reproductive History

(Including all miscarriages, abortions and ectopic pregnancies)

Check here if NEVER pregnant:

Date of Delivery	Term/Preterm	Vaginal or Cesarean	Hours of Labor	Weight	Hospital
<i>Example: 1988</i>	<i>40 weeks</i>	<i>Vaginal</i>	<i>15 hours</i>	<i>6 lbs</i>	<i>UWMC</i>

Please describe any problems you have had with your pregnancies, and tell us what happened:

---



---



---

### Gynecologic History

How old were you when you had your first period? \_\_\_\_\_ What was the date of your last Menstrual period? \_\_\_\_\_

Do you still menstruate?

- YES, regularly (every 25-35 days)       YES, but not regularly  
 How many days are there between periods? \_\_\_\_\_      How many days do your periods last? \_\_\_\_\_  
 NO, I no longer have menstrual periods because of:  
 Natural menopause     Hysterectomy     Don't know     Other: \_\_\_\_\_

Are you currently using any method of birth control?

- not sexually active     Oral contraceptives     Rhythm     Depo-Provera     Other: \_\_\_\_\_  
 post-menopausal     Foam or Jelly     Tubal Ligation     Vasectomy  
 No birth control     Condoms     IUD     Diaphragm     Trying to get pregnant

Have you ever had any of the following sexually transmitted diseases?

- Chlamydia     Syphilis     Herpes     PID/Pelvic Infection  
 Gonorrhea     Trichomonas     Warts     None/Never

Have you had a new sexual partner in the past 6 months?  Yes  No

Have you ever been diagnosed or treated for HPV?  Yes  No

PT.NO

NAME

DOB

Place EPIC Label Matrix Box

**UW Medicine**

Harborview Medical Center – UW Medical Center  
 Northwest Hospital & Medical Center – University of Washington Physicians  
 Seattle, Washington

**WHCC HEALTH HISTORY**

**PAGE 3 OF 6**



\*U2665\*

### Routine Health Care

For all women:

Date of you last pap test? \_\_\_\_\_ Results:  Normal  Abnormal  
Have you ever had an abnormal pap test?  YES  NO If YES, what was done? \_\_\_\_\_

Date of your last Brest examination: \_\_\_\_\_

For all women 40 and over:

Date of your last mammogram: \_\_\_\_\_ Results: \_\_\_\_\_  
Date of your last cholesterol blood test: \_\_\_\_\_ Results: \_\_\_\_\_

For all women 50 and over:

Date of your last stool blood test: \_\_\_\_\_ Results: \_\_\_\_\_  
Date of your last sigmoidoscopy or colonoscopy: \_\_\_\_\_ Results: \_\_\_\_\_

Have you received counseling regarding the pros and cons of hormone replacement therapy use?  YES  NO

For all women 65 and over:

Have you had a bone density test?  YES  NO Results: \_\_\_\_\_

### Immunizations

Measles/mumps/rubella vaccination dates: 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_  Born Prior to 1957

Have you had chicken pox (varicella)?  YES  NO  Don't know  I have had the vaccine

When was your last tetanus/diphtheria shot? \_\_\_\_\_

Have you ever had an influenza vaccination?  YES- Date: \_\_\_\_\_  NO

Have you ever had a pneumonia vaccination?  YES- Date: \_\_\_\_\_  NO

Have you ever had a shingles (Zostivax) vaccination?  YES- Date: \_\_\_\_\_  NO

Hepatitis (age 24 and younger): 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

HPV vaccine?  NO  YES:  1<sup>st</sup>  2<sup>nd</sup>  3<sup>d</sup>

List other immunizations you have had: \_\_\_\_\_

### Diet and Exercise

**On average, how many servings a day do you have of the following:**

High calcium foods (includes 1 cup of milk, 1/2 cup of yogurt, 2 oz. of cheese, or a 300mg Tums or calcium supplement)?  
 None  1  2  3 or more

A piece of fresh fruit, a half cup of vegetables or cut fruit?  None  1-2  3-4  5 or more

High fat foods (such as fatty meats, fast food, eggs, whole milk, cheese, ice cream, donuts, cookies, chips, salad dressings)?  
 None  1  2  3 or more

Over the last year, how often did you skip a meal or eat less than you know you should because there wasn't enough food, or money to buy food?  Never  Less than monthly  Monthly  Weekly  Daily, or almost daily

How many times per week do you exercise? \_\_\_\_\_

Type of exercise: \_\_\_\_\_

Average minutes per exercise session: \_\_\_\_\_

PT.NO

NAME

DOB



**UW Medicine**  
Harborview Medical Center – UW Medical Center  
Northwest Hospital & Medical Center – University of Washington Physicians  
Seattle, Washington

**WHCC HEALTH HISTORY**  
**PAGE 4 OF 6**



\*U2665\*

### Habits

Do you currently smoke cigarettes?  YES  NO If YES, Number per day: \_\_\_\_\_ Year started: \_\_\_\_\_

Have you ever smoked regularly?  YES  NO Date range of smoking: \_\_\_\_\_ until \_\_\_\_\_

How often do you drink alcohol?

Never  Monthly, or less  2-4 times per month  2-3 time per week  4 or more times per week

How many drinks do you have a day when you do drink?

I don't drink  1-2 drinks  3-4 drinks  5 or more drinks

How often in the last year have you had 4 or more drinks on one occasion?

Never  Less than monthly  Monthly  Weekly  Daily or almost daily

Do you use recreational drugs? If so, which one(s): \_\_\_\_\_

### Safety

Do you feel safe in your current living situation?  YES  NO

Have you ever been physically, sexually, or verbally abused?  YES  NO

Is there a smoke detector in your home?  YES  NO

Do you wear a bicycle helmet while riding?  YES  NO

### Health Education

I would like additional written information on the following health related topics: \_\_\_\_\_

Have you had any trouble reading or understanding this form?  YES  NO

How do you like to learn?  Seeing (pictures/videos)  Hearing (listening to people, audiotapes)  Doing (hands on)

Do you have any values or beliefs that we should consider when planning your care?  YES  NO

If YES, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Patient Self-Assessment of Pain

Are you having pain (being in pain) related to your visit today?

YES  NO If NO, please sign the bottom of the last page and return the form to the Medical Assistant or front desk.

Do you want to talk to your health care provider about your pain today?

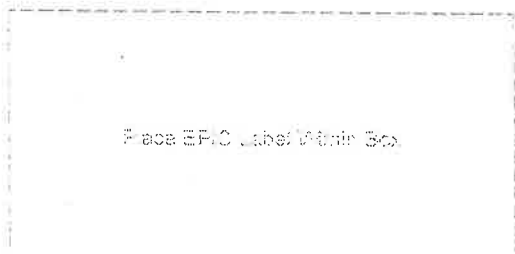
YES  NO If NO, please sign the bottom of the last page and return the form to the Medical Assistant or front desk.

**If you answered YES to both of the questions above, please continue and complete Questions 1-6 before signing.**

PT.NO

NAME

DOB



#### UW Medicine

Harborview Medical Center – UW Medical Center  
Northwest Hospital & Medical Center – University of Washington Physicians  
Seattle, Washington

#### WHCC HEALTH HISTORY

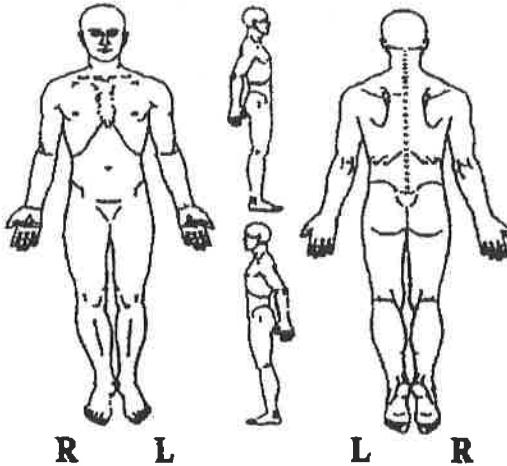
PAGE 5 OF 6



\*U2665\*

**WHCC Health History continued**

1. How long have you had this pain? \_\_\_\_\_

<p><b>2. Where is your pain?</b> <i>On the diagram below, shade the areas where you feel pain. Put an X on the area that hurts the most.</i></p>	<p><b>3. Here is a scale of numbers to use to describe how bad you pain is:</b> 0 1 2 3 4 5 6 7 8 9 10 No Pain <span style="float:right">Worst Pain Imaginable</span></p>
	<p>My AVERAGE pain over the past 24 hours: _____</p> <p>My WORST pain over the past 24 hours: _____</p>
<p><b>4. Circle the word(s) that describe your pain:</b> Aching Heavy Stabbing Burning Radiation Tender Dull Sharp Other: _____</p>	<p><b>5. Circle how often you have pain:</b> Continuous Intermittent</p>

6. What are you doing to decrease your pain? \_\_\_\_\_

Signature (Patient or Authorized Person)	Date	Relationship, if not patient
--	------	------------------------------

**Thank you for your responses. Please return this form to the Medical Assistant or Front Desk  
Do not write below this line**

Patient Unable to Complete Provider Review Comments: \_\_\_\_\_

PHYSICIAN/ARNP/PA SIGNATURE	PRINT NAME	PAGER	NPI	DATE	TIME
-----------------------------	------------	-------	-----	------	------

PT.NO \_\_\_\_\_


NAME \_\_\_\_\_

DOB \_\_\_\_\_

Place EPIC Label Within Box

**UW Medicine**  
Harborview Medical Center – UW Medical Center  
Northwest Hospital & Medical Center – University of Washington Physicians  
Seattle, Washington

**WHCC HEALTH HISTORY**  
**PAGE 6 OF 6**



\*U2665\*

UH2665 REV JAN 13