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:

<table>
<thead>
<tr>
<th>Surgery/Hospitalization/Injury</th>
<th>Date of Diagnosis</th>
<th>Hospital or Treating Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Past Health History

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

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Describe</th>
<th>YES</th>
<th>NO</th>
<th>Describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>Blood Pressure: □</td>
<td>□</td>
<td>Bladder or kidney:</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>Blood Sugar: □</td>
<td>□</td>
<td>Uterus or ovaries:</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>Anemia: □</td>
<td>□</td>
<td>Stomach:</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>Eyes or vision: □</td>
<td>□</td>
<td>Colon/Bowel:</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>Ears or hearing: □</td>
<td>□</td>
<td>Skin disease:</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>Nose or Sinuses: □</td>
<td>□</td>
<td>Arthritis:</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>Thyroid gland: □</td>
<td>□</td>
<td>Depression or Anxiety:</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>Heart: □</td>
<td>□</td>
<td>Anorexia or Bulimia:</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>Lungs/Breathing: □</td>
<td>□</td>
<td>Alcohol or Drugs:</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>Liver/Gallbladder: □</td>
<td>□</td>
<td>DES exposure:</td>
<td></td>
</tr>
<tr>
<td>□</td>
<td>□</td>
<td>Osteoporosis: □</td>
<td>□</td>
<td>Allergies:</td>
<td></td>
</tr>
</tbody>
</table>

Other major health problems: ____________________________

________________________________________________________________________

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WHCC HEALTH HISTORY
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*U2665*

UH2665 REV JAN 13
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:”

<table>
<thead>
<tr>
<th>General:</th>
<th>Weight change without trying</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unusual fatigue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fevers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of appetite</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awakening due to pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling full quickly</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intestinal:</th>
<th>Blood in stool</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal bloating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neurologic/psychiatric:</th>
<th>Loss of memory</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weakness in limbs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness or passing out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numbness or tingling</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Head/eye/ears/throat:</th>
<th>Changes in your eyesight</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoarse voice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty swallowing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty hearing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intestinal:</th>
<th>Blood/growths:  Bleeding from gums</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Swollen lymph nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breast lump or pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lump or mass elsewhere</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Glands/endocrine:</th>
<th>Thirsty all of the time</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can’t stand heat or cold</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lungs:</th>
<th>Shortness of breath</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coughing up blood</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheezing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gynecologic/urinary:</th>
<th>Pelvic pain</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregular or heavy periods</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding after menopause</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood in urine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain with intercourse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unusual vaginal discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge color</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any other health concerns that your provider should know about today? If yes, please explain: ___________________________  □ Yes  □ No

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
Family History

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

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>RELATIONSHIP</th>
<th>AGE</th>
<th>YES</th>
<th>NO</th>
<th>RELATIONSHIP</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Breast Cancer</td>
<td></td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ovarian Cancer</td>
<td></td>
<td></td>
<td></td>
<td>Heart Disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colon Cancer</td>
<td></td>
<td></td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Cancers</td>
<td></td>
<td></td>
<td></td>
<td>Osteoporosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other Illnesses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What:

Reproductive History

(Including all miscarriages, abortions and ectopic pregnancies)

Check here if NEVER pregnant: 

<table>
<thead>
<tr>
<th>Date of Delivery</th>
<th>Term/Preterm</th>
<th>Vaginal or Cesarean</th>
<th>Hours of Labor</th>
<th>Weight</th>
<th>Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: 1988</td>
<td>40 weeks</td>
<td>Vaginal</td>
<td>15 hours</td>
<td>6 lbs</td>
<td>UWMC</td>
</tr>
</tbody>
</table>

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

☐ 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  ☐ Diaphragm  ☐ Trying to get pregnant

☐ No birth control  ☐ Condoms  ☐ IUD  ☐ None/Never

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

W H C C  H e a l t h  H i s t o r y  c o n t i n u e d
**Routine Health Care**

**For all women:**
Date of your 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 breast 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: 1st ____________ 2nd ____________ □ 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 (Zostavax) vaccination? □ YES- Date: ____________ □ NO

Hepatitis (age 24 and younger): 1st ____________ 2nd ____________ 3rd ____________

HPV vaccine? □ NO □ YES: 1st ____________ 2nd ____________ 3rd ____________

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, ½ 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: ____________

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**WHCC HEALTH HISTORY**

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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.
1. How long have you had this pain?

2. Where is your pain?
   On the diagram below, shade the areas where you feel pain. Put an X on the area that hurts the most.

3. Here is a scale of numbers to use to describe how bad you pain is: 0 1 2 3 4 5 6 7 8 9 10
   No Pain          Worst Pain
   Imaginable

   My AVERAGE pain over the past 24 hours:__________
   My WORST pain over the past 24 hours:__________

4. Circle the word(s) that describe your pain:
   - Aching
   - Heavy
   - Stabbing
   - Burning
   - Radiation
   - Tender
   - Dull
   - Sharp
   - Other:__________

5. Circle how often you have pain:
   - Continuous
   - Intermittent

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

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