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
☐	☐	Blood Pressure**:**	☐	☐	Bladder or kidney**:**
☐	☐	Blood Sugar:	☐	☐	Uterus or ovaries:
☐	☐	Anemia:	☐	☐	Stomach:
☐	☐	Eyes or vision:	☐	☐	Colon/Bowel:
☐	☐	Ears or hearing:	☐	☐	Skin disease:
☐	☐	Nose or Sinuses:	☐	☐	Arthritis:
☐	☐	Thyroid gland:	☐	☐	Depression or Anxiety:
☐	☐	Heart:	☐	☐	Anorexia or Bulimia:
☐	☐	Lungs/Breathing:	☐	☐	Alcohol or Drugs:
☐	☐	Liver/Gallbladder:	☐	☐	DES exposure:
☐	☐	Osteoporosis:	☐	☐	Allergies:

Other major health problems: _____

PLACE PATIENT LABEL HERE

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**:"

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

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.

YES	NO		RELATIONSHIP	AGE	YES	NO		RELATIONSHIP	AGE
☐	☐	Breast Cancer			☐	☐	Diabetes		
☐	☐	Ovarian Cancer			☐	☐	Heart Disease		
☐	☐	Colon Cancer			☐	☐	High Blood Pressure		
☐	☐	Other Cancers			☐	☐	Osteoporosis		
☐	☐	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
Example: 1988	*40 weeks*	*Vaginal*	*15 hours*	*6 lbs*	*UWMC*

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)
How many days are there between periods? _____

☐ **YES**, but not regularly
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

PLACE PATIENT LABEL HERE

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 (Zostivax) 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: _____

PLACE PATIENT LABEL HERE

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?

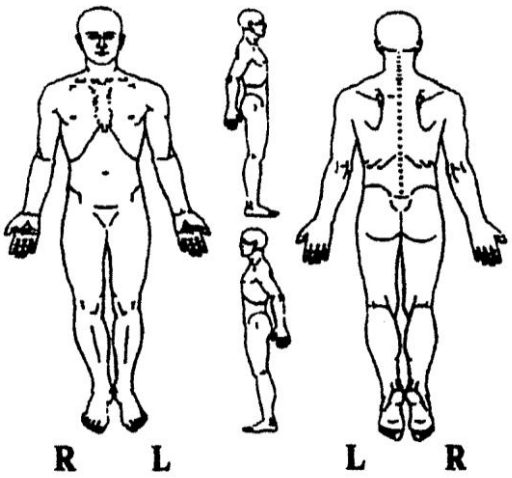
☐ YES ☐ NO If NO, please sign the bottom of the last page and return the form to the Medical Assistant or front desk.

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

PLACE PATIENT LABEL HERE

WHCC Health History continued

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

PLACE PATIENT LABEL HERE