NORTHWEST
Family Practice

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Health History

Name____________________ Date of birth__________ Sexual orientation________

Male___ Female____ Other____ Marital status__________ Phone__________ Cell__________

Street address____________________ City__________ State______ Zip________

Email____________________ Insurance____________________

Do you need an interpreter for your office visits: Yes____ No___ Pharmacy____________________

Medical History (circle below if you have had any of the following):

Allergies/Hay Fever	Artery Blockage	Fatigue	Anemia	DVT
Glaucoma	High Blood Pressure	Fibromyalgia	HIV/AIDS	Anxiety
Hearing Loss	High Cholesterol	Thyroid Problems	Arthritis	Bipolar Disorder
Rhinitis	Palpitations	Diverticulitis	Back Pain	Depression
Visual Loss	Vascular Disease	Hepatitis	Sciatic Pain	Anxiety
Breast Lump	Stroke	Hernia	Joint Pain	Asthma
Breast Cancer	Eczema	Spastic Colon	Epilepsy	COPD/Emphysema
Arrhythmia	Skin Cancer	Ulcer	Meningitis	Pneumonia
Heart Attack	Skin Problems	Reflux	Migraine	Tuberculosis
Heart Murmur	Diabetes	Abnormal Periods	Edema	Bladder/Kidney Infection

Other problems not listed____________________

Have you had cancer (list type and treatment)____________________

Have you had any of the tests below:

	Date	Reason	Where was the test done?
Heart Test			
Ultrasound			
CT Scan			
MRI			
Bone Density			
Colonoscopy			
Sigmoidoscopy			
Mammogram			

Past surgical history (include date or age you had the surgery):

Date	Surgery

List all medications, vitamins, supplements, over the counter medications (with dosage):

I don't take medication

Name of Medication	Dosage	Directions

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List all allergies (medications, environmental, and food):

Medication ______ Environmental or food ______

______
______
______
______

Vaccinations (date of last):

Tetanus/Tdap______ Flu______ Pneumonia______ Shingles______

Family medical history:

	Medical problems	Living or deceased	Age at death
Father			
Mother			
Sibling			
Sibling			
Other			

Social history:

Present occupation______ Past occupation______ Highest level of education______

Have you served in the military______ Places you have lived______

Religious preference______ Is faith important to your health______

Do you or have you had a drinking problem______

Do you consume alcohol______ Last drink______

How many drinks a week______

Do you use recreational drugs______ What drugs______

Do you smoke______ Age started______ Age quit______ Packs per day______

Do you exercise______ How often______ What type of exercise______

What is your favorite food______ Least favorite food______

Do you have any of the following symptoms (circle all that apply if you have any of the following):

Weight Gain	Bloody Nose	Abdominal Pain	Genital Sores	Too Thirsty
Weight Loss	Cough	Nausea/Vomiting	Rash	Voice Change
Night Sweats	Swallowing Issues	Diarrhea	Skin Changes	Change in Energy
Fever/Chills	Bleeding Gums	Constipation	Nail Changes	Easy Bleeding
Headaches	Breast Lumps	Bloody Stools	Fainting	Easy Bruising
Visual Changes	Nipple Discharge	Heartburn	Seizures	Swollen Glands
Dizzy/Vertigo	Chest Pain	Impotence	Numbness	Anemia
Earache	Palpitations	Bloody Urine	Paralysis	Depression
Allergies	Swelling	Frequent Urination	Tremors	Anxiety
Ringing in Ears	Wheezing	Painful Urination	Memory Problems	Trouble Sleeping
Deafness	Short of Breath	Past-Sexual Abuse	Back Pain	Thoughts of Suicide
Sinus Problems	Poor Appetite	Sexual Problems	Joint Pain/Swelling	Hallucinations

Women:

Number of pregnancies______ Deliveries______ Miscarriages______ Abortions______ Ectopic pregnancies______

Age menses started______ Age menses stopped______ Last period______ Last PAP smear______

Do you have:

Painful periods______ Pain with sex______ Irregular periods______ Problems getting pregnant______

Are you sexually active______ Using any type of birth control______

What birth control have you used in the past______