Patient Health History

Name: DOB:

Age:

Past Medical History:

Please check all that apply:

- ☐ Anemia
- ☐ Bleed/Bruise easily
- ☐ Blood Clots/Phlebitis
- ☐ Cancer
- ☐ Enlarged lymph nodes
- ☐ Stroke
- ☐ Seizures
- ☐ Migraine Headaches
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Thyroid disorders
- ☐ Hives or Eczema
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Circulatory Problems
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart rhythm problems
- ☐ Mitral Valve Prolapse
- ☐ High Blood Pressure (Hypertension)
- ☐ Low Blood Pressure
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Kidney problems
- ☐ Urinary infections
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Ulcers
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Emotional Problems
- ☐ Substance abuse

Infections:

- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Whooping cough
- ☐ Scarlet fever
- ☐ Diphtheria
- ☐ Small pox
- ☐ Tuberculosis
- ☐ Rheumatic fever
- ☐ Infectious mono
- ☐ AIDS or HIV
- ☐ Venereal Disease

☐ Other: _____

Past Surgical History:

☐ Never had Surgery

☐ Had Surgery

Reason for Surgery	Location:	Date:

Procedures:

☐ Never had a colonoscopy

☐ Had a colonoscopy. Date:_____

☐ Had other colorectal cancer screening. Test:_____Date:_____

Patient Health History

Name: DOB:

Gynecologic History:

*Are you Pregnant: Y / N
Number of pregnancies(Gravida): _____
Number of deliveries(Para): _____
Age at first Birth: _____
# of interrupted pregnancies: _____
Miscarriages: _____
Abortions: _____

Age at first period: _____
Age at menopause: _____
☐ Hormone Use
☐ Contraceptive Use # years _____
☐ Post Menopausal Use # years _____
☐ Other Hormone Use # years _____

Date of last PAP: _____
Date of last Mammogram: _____

Family History:

Biological Father
Age: _____
☐ Living ☐ Deceased ☐ Unknown
Cause of Death: _____
Medical Problems: _____

Biological Mother
Age: _____
☐ Living ☐ Deceased ☐ Unknown
Cause of Death: _____
Medical Problems: _____

Biological Brother(s)
# of living brothers: _____ Age(s): _____
# of deceased brothers:_____ Age(s): _____
Cause of Death: _____
Medical Problems: _____

Biological Sister(s)
# of living sisters: _____ Age(s): _____
# of deceased sisters:_____ Age(s): _____
Cause of Death: _____
Medical Problems: _____

Biological Children
# of living sons: _____ daughters: _____
# of deceased sons:_____ daughters:_____
Cause of Death: _____
Medical Problems: _____

Other Family Problems include:

_____

_____

Social History:

Marital Status:
☐ Single
☐ Married
☐ Separated
☐ Divorced
☐ Widowed

Smoking Status:
☐ Yes - every day smoker
☐ Yes - some day smoker
☐ Yes - but Quit
☐ Never
☐ Smoker - status unknown
☐ Heavy tobacco smoker (> 10 cig/day or cigars)
☐ Light tobacco smoker (<10 cigs/day)

# of years: _____
Packs/Day: _____
of Years Quit: _____

Alcohol Consumption:
☐ Yes - every day drinker
☐ Yes - some day drinker
☐ Yes - but Quit
☐ Never
Days/Week:_____
Drinks/Day _____
of Years Quit: _____

Occupation:_____

Review of Systems

Name: DOB:

Constitutional Symptoms
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Loss of appetite
- ☐ Fever/Chills
- ☐ Night sweats
- ☐ Fatigue
- ☐ Headache

Skin
- ☐ Rash
- ☐ Itching
- ☐ Changes in skin color
- ☐ Changes in hair or nails
- ☐ Changes in Mole(s)
- ☐ Varicose veins

Eyes
- ☐ Visual Problems
- ☐ Blurred or double vision
- ☐ Eye Disease or Injury
- ☐ Wear glasses/contact lenses

Ears/Nose/Throat/
- ☐ Hearing loss or ringing
- ☐ Earaches or drainage
- ☐ Chronic sinus problems
- ☐ Nose bleeds
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Bad breath or bad taste
- ☐ Sore throat
- ☐ Voice Changes

Heart/Lungs
- ☐ Chest pain
- ☐ Palpitations
- ☐ Short of breath
- ☐ Short of breath at night
- ☐ Short of breath - worse with exertion
- ☐ Cough
- ☐ Cough up blood
- ☐ Swelling in legs, feet, or hands
- ☐ Wheezing

Gastrointestinal
- ☐ Loss of appetite
- ☐ Abdominal pain
- ☐ Nausea or Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Painful bowel movements
- ☐ Rectal bleeding/blood in stool
- ☐ Special Diet

Urinary
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Lack of control/incontinence
- ☐ Blood in urine
- ☐ Kidney Stone

Musculoskeletal
- ☐ Joint pain/swelling
- ☐ Muscle pain/swelling
- ☐ Back pain
- ☐ Bone pain
- ☐ Difficulty walking
- ☐ Cold extremities

Neurological/Emotional
- ☐ Headaches
- ☐ Dizziness
- ☐ Seizures
- ☐ Jerking/twitching
- ☐ Numbness/tingling
- ☐ Anxiety
- ☐ Depression
- ☐ Fainting Spells
- ☐ Confusion
- ☐ Memory loss
- ☐ Insomnia

Endocrine
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Thyroid condition

Gynecological
- ☐ Vaginal bleeding
- ☐ Changes in Menses
- ☐ Discharge

Length of last menses: _____

Needs Assessment: Illness can often affect a person's emotions in many ways.

Since your illness have you felt any of the following?
- ☐ Anxious or more anxious than usual
- ☐ Depressed or more depressed than usual
- ☐ Angry
- ☐ Overwhelmed by emotion
- ☐ Sad
- ☐ Other:

Whom do you rely on for emotional support?
- ☐ Parents
- ☐ Spouse/Significant Other
- ☐ Neighbors/Friends
- ☐ Support Group
- ☐ Counselor/Therapist
- ☐ Church
- ☐ Other: _____

Have you ever been seriously ill in the past? ☐ Yes ☐ No

Are you concerned about how your illness will affect your financial resources? ☐ Yes ☐ No

Are you concerned about how your illness will affect your work? ☐ Yes ☐ No

Do you have any concerns about transportation? ☐ Yes ☐ No

Do you have any concerns you would like to talk to a nurse doctor/counselor about as a result of your illness?
- ☐ Not at this time
- ☐ Your appearance
- ☐ Personal relationships
- ☐ Being a parent
- ☐ Keeping your job
- ☐ Staying in school
- ☐ Your sexual functioning
- ☐ Ability to have children
- ☐ Other: _____

What concerns you most about your illness?_____

Are there any other questions we can help you answer? _____