

_____ (print) patient name

Past Medical History: Please check all that apply to you:

- _____ heart failure
- _____ heart attack
- _____ high blood pressure
- _____ high cholesterol
- _____ diabetes
- _____ other heart disease
- _____ stroke
- _____ seizures
- _____ headache
- _____ esophageal reflux
- _____ stomach ulcer
- _____ depression
- _____ anxiety

- _____ arthritis
- _____ asthma
- _____ emphysema (COPD)
- _____ tuberculosis
- _____ pneumonia
- _____ HIV
- _____ thyroid disease
- _____ cancer
- _____ type _____
- _____ other chronic medical problems
- 1.
- 2.
- 3.

Please list any hospitalizations and surgeries with approximate dates:

Blood transfusions Yes or No

How many hours a night do you sleep? _____ Any trouble falling asleep? Yes or No
Any trouble staying asleep? Yes or No

Birthplace: _____ Is Tampa area your primary home? _____

Education: ___ middle school ___ high school ___ college degree ___ post college degree

Occupation: _____

Are you a caregiver for a family member? Yes or No

If yes, briefly describe your role _____

What are your hobbies? _____

Do you eat a balanced diet? Yes or No Describe any special feature: _____

Do you consider yourself the appropriate weight? Yes or No

If No, what do you think an appropriate weight would be for you? _____

Do you get regular exercise? _____ Describe: _____

Do you see a dentist? Yes or No Last visit date: _____

Do you see an eye doctor? Yes or No Last visit date: _____

How often do you wear seat belts? always occasionally never (circle one)

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Do you have firearms/guns in your household? Yes or No If yes, do you have trigger locks? Yes or No

Tobacco use: Smoking history: never smoked _____ started (age) _____ stopped (age) _____

How many packs per day do you now smoke (or did you smoke in the past?) _____

Do you dip or chew tobacco? Yes or No

Do you drink alcoholic beverages? Yes or No

If yes, please estimate how much you drink: _____ Glasses/cans per day/week/month (circle one)

Do you drink (check all that apply): hard liquor _____ beer _____ wine _____

Have you ever had a drinking problem? Yes or No When was your last drink? _____

How many cups of coffee, tea, or other caffeine products (like Coke) do you drink daily? _____

Do you use, or have you used marijuana, cocaine, IV drugs, or other street drugs? _____

Who lives with you in your home? (spouse/partner, children, in-laws, boyfriend, girlfriend, pets (dogs, cats, other animals) _____

Married? Yes or No How many years? _____ Occupation (spouse/partner): _____

Do you have a "living will" or other advanced directive Yes or No

If yes, where is it filed? _____

If no, would you like information today? Yes or No If yes, date given: _____ nurses initials _____

Were you adopted? Yes or No If no, complete the following table:

	GENDER	Age	Living	Deceased	Illnesses*	Cause of death	General health
FATHER	M						
MOTHER	F						
BROTHERS							
And SISTERS							
Spouse/partner							
CHILDREN							
(List in							
order of age)							

*Please include cancer and what type, diabetes, heart attacks, high blood pressure, strokes, tuberculosis, and other important illnesses.

Preventive Healthcare:

Indicate the last time the following were performed (or “never”):

Immunizations and vaccines:

Tetanus: _____ Pneumovax (pneumonia): _____

Hepatitis B series: _____ Hepatitis A series: _____

Varicella (chickenpox): _____ Zostavax (shingles): _____

Gardasil (girls and women only): _____ Other vaccinations: _____

Health Maintenance Tests:

Approximate dates and outcomes:

Sigmoidoscopy: _____ Stool occult blood testing: _____

Colonoscopy: _____ Bone Density test _____

Men only: Prostate Exam: _____ PSA – Prostatic specific antigen: _____

Women only: Pap smear: _____ Mammogram: _____

Do you perform monthly breast self-examinations? _____

How do you rate your overall health: excellent good fair poor (circle one)

Please check any of the following that apply to you:

YES NO

____ History of STI’s (sexually transmitted infections):
(HPV, genital warts, chlamydia, herpes, gonorrhea, syphilis, other _____)

____ have you ever been tested for HIV disease?
If Yes, what year? _____
If No, would you like to be tested? Yes or No

Sexual Preference: heterosexual, homosexual, bisexual, or prefer to discuss with doctor (circle one)

YES NO

____ Do you feel safe in your current relationship?

____ Do you feel afraid of a partner/spouse?

____ Have you ever, or are you currently suffering abuse (slapping, hitting, choking, yelling, threatening) in your relationship? If Yes:

Are your friends and family aware of any problems/abuse in your relationship? Yes or No
Do you have an emergency escape plan and somewhere safe to go? Yes or No

Please check any of the following that you are bothered by

- | <u>YES</u> | <u>NO</u> | |
|------------|-----------|--|
| _____ | _____ | weight gain |
| _____ | _____ | weight loss |
| _____ | _____ | fever or chills |
| _____ | _____ | night sweats |
| _____ | _____ | thyroid problems |
| _____ | _____ | thirst or frequent urination |
| _____ | _____ | eyeglasses or contact lenses |
| _____ | _____ | eye pain, vision problems (spots, blurriness) |
| _____ | _____ | difficulty hearing |
| _____ | _____ | ringing in ears |
| _____ | _____ | chronic runny or stuffed nose |
| _____ | _____ | severe nose bleeds |
| _____ | _____ | hoarseness or voice change |
| _____ | _____ | sinus problem |
| _____ | _____ | chest pain |
| _____ | _____ | palpitations (rapid heard beats) |
| _____ | _____ | spells of unconsciousness |
| _____ | _____ | pain in legs while walking |
| _____ | _____ | swelling of the legs/ankles |
| _____ | _____ | shortness of breath with exertion |
| _____ | _____ | shortness of breath when laying flat in bed |
| _____ | _____ | painful urination |
| _____ | _____ | frequent urination |
| _____ | _____ | blood in urine |
| _____ | _____ | kidney stones |
| _____ | _____ | history of urinary tract infection |
| _____ | _____ | need to get out of bed to urinate?
If yes, how man times? _____ |

- | <u>YES</u> | <u>NO</u> | |
|------------|-----------|---|
| _____ | _____ | cough or sputum (phlegm) production |
| _____ | _____ | coughing up blood |
| _____ | _____ | chronic bronchitis |
| _____ | _____ | wheezing |
| _____ | _____ | environment or occupational exposure to asbestos |
| _____ | _____ | history of blood clots in legs or lungs |
| _____ | _____ | loss of appetite |
| _____ | _____ | nausea or vomiting |
| _____ | _____ | heartburn |
| _____ | _____ | abdominal pain |
| _____ | _____ | diarrhea, constipation, or change in bowel habits |
| _____ | _____ | yellow jaundice or liver disease |
| _____ | _____ | blood in stool |
| _____ | _____ | black and tarry stools |
| _____ | _____ | hemorrhoids |
| _____ | _____ | stomach ulcers |
| _____ | _____ | gallbladder disease |
| _____ | _____ | anemia (low blood count) |
| _____ | _____ | blood transfusion |
| _____ | _____ | excessive bleeding or bruising |
| _____ | _____ | joint stiffness, pain or swelling |
| _____ | _____ | previous mental illness |
| _____ | _____ | anxiety |
| _____ | _____ | depression |
| _____ | _____ | attempted suicide |
| _____ | _____ | severe or frequent headaches |

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WOMEN:

YES NO

- ___ ___ vaginal discharge or infections
- ___ ___ painful intercourse or sexual difficulty
- ___ ___ abnormal vaginal bleeding
- ___ ___ do you douche vaginally? if so, how often? _____
- ___ ___ breast lump, pain, or nipple discharge
- _____ date of first day of last menstrual period
- _____ age of first period: _____
- _____ age of first sexual encounter (intercourse): _____
- _____ age of menopause: _____
- _____ number of days of menstrual flow per cycle: _____
- _____ flow: mild moderate heavy (circle one)
- _____ number of days between successive periods: _____
- _____ number of pregnancies: _____ number of children: _____
- _____ history of abnormal Pap smears: _____
- _____ history of female surgeries (hysterectomy, tubes tied, D&C, other): _____

MEN:

YES NO

- ___ ___ discharge from penis
- ___ ___ lump or pain in testicles
- ___ ___ problems with erections
- ___ ___ decreased sex drive/desire
- ___ ___ difficulty with urine stream

Please list recent past physicians with address and specialty who have cared for you:

1. _____
2. _____
3. _____

Who completed this form? Patient ___ Relative ___ If so, what relationship? ___ Friend ___

Patient Signature

Date

THANK YOU for completing this 6 page Health History. It will help us provide YOU with better care.

Do not write below this line

I reviewed this patient's history form.

Health Care Provider's Signature

Date