Highland Family Practice Health History Form

Name_____ Age_____ Date of Birth_____ Today's Date_____
Occupation_____ Retired? *Yes No*
Sex: *Male Female* Marital Status: *Married Single Divorced Widowed*
Reasons for Exam:_____

Medication and Strength	How Often	Medication and Strength	How Often	Medication and Strength	How Often
1._____	_____	5._____	_____	9._____	_____
2._____	_____	6._____	_____	10._____	_____
3._____	_____	7._____	_____	11._____	_____
4._____	_____	8._____	_____	12._____	_____

Medication allergies, sensitivities and intolerances:_____
_____

Past Surgery	Year	Past Surgery	Year	Past Surgery	Year
1._____	_____	4._____	_____	7._____	_____
2._____	_____	5._____	_____	8._____	_____
3._____	_____	6._____	_____	9._____	_____

Other Hospitalization	Year	Other Hospitalization	Year	Other Hospitalization	Year
1._____	_____	4._____	_____	7._____	_____
2._____	_____	5._____	_____	8._____	_____
3._____	_____	6._____	_____	9._____	_____

Are you a smoker?	*Yes No*	Packs per day _____ How many years?_____
Are you a former smoker?	*Yes No*	Packs/day_____ Years smoked____ Year quit____
Do you drink alcohol?	*Yes No*	Drinks per day/week/month_____
Are you a recovering alcoholic?	*Yes No*	When did you quit?_____
Do you use marijuana or other drugs?	*Yes No*	
Do you use your seatbelt regularly?	*Yes No*	
Do you drink caffeinated drinks?	*Yes No*	Ounces/glasses per day_____
Do you exercise?	*Yes No*	Frequency per week_____
If you have guns in your home, are they kept locked up?	*Yes No*	

List the year of your last:

MMR vaccination	____	Hepatitis A vaccination	____	HIV test	____	Pap Smear	____
Tetanus vaccination	____	Hepatitis B vaccination	____	Sigmoidoscopy	____	Mammogram	____
Pneumonia vaccination	____	Tuberculosis skin test	____	Colonoscopy	____	Bone Density	____
Meningitis vaccine	____	Flu shot	____	Chest X-ray	____	PSA test	____

Please circle any of the following illnesses and/or medical problems you have or have had:

Glaucoma	High cholesterol	Anemia	Depression
Cataracts	Rheumatic fever	Endometriosis	Anxiety
Thyroid problems	Stomach/duodenal ulcers	Pelvic inflammation	AIDS or HIV
Emphysema	Reflux/heartburn	Abnormal Pap	Bleeding problems
Pneumonia	Diverticulosis	DES exposure	Convulsions/seizures
Hay fever	Colitis	Breast problems	Arthritis
Tuberculosis	Hepatitis	Sexually transmitted disease	Gout
High blood pressure	Liver trouble	Prostate problems	Cancer
Heart attack	Gallbladder problems	Kidney/bladder problems	Blood Transfusion
Arteriosclerosis	Hernia	Kidney stones	Intravenous drug abuse
Stroke	Diabetes	Blood clots in arteries or veins	Tattoos
Asthma	Chicken Pox	Other:_____	

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Your Biological Family History (list all members, even if healthy)

Relation	Sex	Age, if living	Age at death	Medical problems and/or cause of death; write "well" if healthy
Father				
Mother				
Brother/Sister				
Children				

If not listed above, please indicate if a child, brother, sister, mother, or father have had any of the following:

High blood pressure_____ Blood clots in arteries or veins_____ Glaucoma_____
Stroke_____ Heart Disease_____ Depression_____
Diabetes_____ Cancer_____ Alcoholism_____
Tuberculosis_____ Asthma_____ Emphysema_____
Suicide_____ Other_____

Review of Body Systems

	Never or not bothersome	Frequent or bothersome		Never or not bothersome	Frequent or bothersome
Severe headaches			Constipation		
Nose or throat problems			Diarrhea		
Shortness of breath			Bloody, black, or purple stools		
Cough blood			Painful urination		
Wheezing			Urgency with urination		
Chest pain with exercise			Hard to start urine flow		
Joint pains			Urinary frequency at night		
Rapid or irregular heart beat			Lose urine control		
Swollen ankles or feet			Dark or bloody urine		
Fainting spells			Continuous ringing in the ears		
Nausea			Eye pain		
Trouble swallowing food			Numbness		
Vomiting blood			Tremors		
Skin lesions or abnormal moles			Weakness or paralysis		
Lose balance			Stop breathing when asleep		
Coordination problems					
Falling asleep at work or when driving					

Females only:

Age menstruation started_____ How often do you have periods?_____ How long are your periods?_____
How many pregnancies have you had?_____ How many live children do you have?_____
Any vaginal itching/burning/sores? *Yes No* Describe_____
Any breast changes? *Yes No* Describe_____
Any menopausal symptoms? *Yes No* Describe_____
Do you use birth control? *Yes No* Describe_____
Sexual problems? *Yes No* Describe_____
If postmenopausal, have you had any vaginal bleeding? *Yes No* Describe_____

Males only:

Sores or lesions on the penis? *Yes No* Discharge from the penis? *Yes No*
Pain or swelling in the testicles? *Yes No* Sexual problems or impotence? *Yes No*