Highland Family Practice
Health History

Name_____Age_____Date of Birth_____Today's Date_____

Gender: *Male Female Transgender man (FTM) Transgender woman (MTF) Gender nonconforming Other*

Sex on birth certificate: *Male Female Decline to answer*

Reasons for Exam: _____

List the year of your last:

Flu shot	_____	Meningitis vaccine	_____	TB test	_____	Pap Smear	_____
Chicken pox vaccine	_____	MMR vaccine	_____	HIV test	_____	Mammogram	_____
COVID-19 vaccine	_____	Pneumonia vaccine	_____	Sigmoidoscopy	_____	Bone Density	_____
Hepatitis A vaccine	_____	Shingles Vaccine	_____	Colonoscopy	_____	PSA test	_____
Hepatitis B vaccine	_____	Tetanus vaccine	_____	Chest X-ray	_____		

Review of Current Symptoms

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

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*

Provider Name: _____
Date: _____