



### Health History:

Disease/Condition	Date / Explain	Disease/Condition	Date / Explain
Seizures		Reflux/GERD	
Head Trauma		Colon Cancer	
Cerebral Aneurysm		Hemorrhoids	
Stroke/TIA		Colon Polyps	
Alzheimer's		Diverticulitis/diverticulosis	
Migraine		Crohn's Disease	
Trouble Seeing		Colitis	
Glaucoma		Irritable bowel	
Cataracts		Liver Disease	
Hard of Hearing/Deafness		Hepatitis	
Blood Transfusion		Kidney Disease	
Anemia		Bladder Cancer	
Blood clots in legs/lungs		Frequent UTI (urinary tract infections)	
History of Heart Attack		Psoriasis/Eczema	
Angina/chest pain		Skin Cancer	
High Blood Pressure		Breast Cancer	
High Cholesterol		Abnormal Mammogram	
Heart Failure (CHF)		Diabetes	
Atrial Fibrillation		PreDiabetes	
Murmur		Thyroid problem	
Asthma		Gout	
Emphysema/COPD		Rheumatoid Arthritis	
Sleep Apnea		Arthritis	
Lung Cancer		Osteoporosis/Osteopenia	
Tuberculosis		Pain	
Positive PPD		Anxiety	
HIV		Bipolar	
Shingles		Depression	
Rheumatic Fever		Suicide Attempt	
Lyme Disease		Schizophrenia	
Chlamydia		Eating Disorder	
Gonorrhea		PTSD	
Herpes		ADD/ADHD	
Genital Warts/HPV		Drug Addiction	
Chicken Pox Disease		Alcoholism	

**OTHER:** \_\_\_\_\_

**Females:**  Abnormal Pap smear  LEEP  Colposcopy  Cone Biopsy  Cervical Cancer  Uterine Cancer

Describe above: \_\_\_\_\_

Date of last PAP: \_\_\_\_\_ Who did the PAP \_\_\_\_\_ Date of Menopause \_\_\_\_\_

Gestational Diabetes (diabetes during pregnancy)  DES Exposure # Pregnancies \_\_\_\_\_ # Deliveries \_\_\_\_\_

# Miscarriage \_\_\_\_\_ # Abortion \_\_\_\_\_  Ectopic (tubal) pregnancy Comments: \_\_\_\_\_

**Males:**  Testicular Cancer  Prostate Cancer  Prostatitis  Enlarged prostate (BPH)  Undescended testicle

Erectile Dysfunction Comments: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**Patient Date of Birth** \_\_\_\_\_

**Surgeries: (Please be as specific as possible- example: left hip replacement)  No known surgeries**

Surgery	Date of Surgery/ Reason

**Family medical history: Please be specific for cancers (kind, location if known)  I do not know my family history**

	Conditions/Diseases
Mother	
Father	
Sister (s)	
Brothers (s)	
Children	
Grandparents	
Other:	

**Sexual Health:** Sexual Preference:  Male  Female  Both

Are you sexually active?  Yes, Currently  No, have been in past  No, Never

# Current Partners \_\_\_\_\_ # Lifetime Partners \_\_\_\_\_ Has any partner used IV drugs?  No  Yes  Unsure

What are you using to prevent pregnancy? \_\_\_\_\_ Do you use condoms :  Sometimes  Always  Never

**Social and Health Habits:**

How often do you drink alcohol? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Never <input type="checkbox"/> Rarely
What do you drink? _____
Is your alcohol use a concern for you or others? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain: _____
Do you use cocaine or other recreational drugs? <input type="checkbox"/> Currently <input type="checkbox"/> Never <input type="checkbox"/> Past/Former
What drugs? _____
Do you now or have you ever had a problem with prescription drug use? <input type="checkbox"/> Currently <input type="checkbox"/> Never <input type="checkbox"/> Past/Former
What drugs? _____
Do you feel emotionally, financially, sexually, verbally or physically abused? <input type="checkbox"/> Current <input type="checkbox"/> Never <input type="checkbox"/> In the Past
Comments: _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Who do you live with? _____
Employment Status: <input type="checkbox"/> Seeking employment <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> On LOA <input type="checkbox"/> Work Full-time <input type="checkbox"/> Work Part-Time <input type="checkbox"/> Work Per-diem
Occupation: _____

**Patient Signature:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_