BSW Douglass Community Clinic Health History Form

NAME: **Date:**
DATE OF BIRTH:
SEX: FEMALE MALE

Let us know if you have had any of these complaints lately (circle):

GENERAL: Appetite Loss, Dizziness, Fatigue, Fever, Weakness, Unintentional Weight Loss or Gain, Trouble Sleeping.

EYES: Discharge, Halos, Irritation, Blurry Vision, Glaucoma, Cataracts, Glasses or Contacts,

Last eye Exam ___________

ENT: Allergies, Trouble Swallowing, Snoring, Ear Ache, Hearing Loss, Nasal Congestion, Post Nasal Drip, Sneezing, Sinus Pain, Sore Throat, Hoarseness, Last Dental Exam__________

CARDIO: Chest Pain/Discomfort, Calf Pain when Walking, Palpitations. Swelling of Hands or Feet, Passing Out, Shortness of Breath with Activity, Difficulty Breathing with Lying down

RESPIR: Chest Congestion, Cough (dry/wet/productive), Coughing up Blood, Shortness of Breath Wheezing

GI: Bloating, Abdominal Pain, Changes in Bowel Movements, Constipation, Diarrhea, Heartburn, Black Stools, Nausea/Vomiting, Blood in Stool, Swallowing Difficulties

GU (Women) Breast Pain, Nipple Discharge, Decreased Sexual Drive, Painful Urination, Blood in Urine, Incontinence, Menstrual Irregularity, Pelvic Pain, Urinary Urgency, Urinary Frequency, Vaginal discharge, Vaginal dryness, Hot Flashes

GU (Men) Decreased Sexual Drive, Decreased Urinary Flow, Discharge from Penis, Painful Urination, Erectile Dysfunction, Blood in Urine, Incontinence, Frequent Nightly Urination

MS Back Pain, Joint Pain, Joint Swelling, Muscle Aches

DERM: Acne, Hair Loss, Nail Problems, Itching, Rash, Suspicious Lesions

NEURO: Trouble Walking, Double Vision, Falling Frequently, Headaches, Muscle Weakness, Seizures, Sudden Loss of Vision, Tremors, Memory Loss, Numbness

PSYCH: Anxiety, Depression, Insomnia, Little Pleasure Doing Things

ENDO: Excessive Thirst, Excessive Urination, Temperature Intolerance

HEME: Abnormal Bleeding, Easy Bruising, Enlarged Lymph Nodes

ALLERGY: Itchy Eyes, Hives, recurrent Infection, Seasonal Allergy

NAME:
DATE OF BIRTH:
Please circle to medical conditions you have currently had or had in the past:

Angina (chest pain)
Heart Failure
Irregular Rhythm
Heart Attack
Asthma
High Blood Pressure
Diabetes (Type I or II)
Memory Problems
High Cholesterol
Arthritis
Cancer
Pain
Anxiety
Depression
Thyroid Condition
Stroke
Kidney Problems
Urinary/Bladder problems
Stomach Ulcers
Pregnancies # _____
Other_______________________

Surgery	**Date**	**Hospital**

Please list prescriptions, vitamins, supplements, over the counter meds, and herbal remedies you take**.**

Are you allergic to any medications? Y/N If yes, what medication: _________________________________
Immunizations (estimate when given): Tetanus_____ Pneumonia______ HepB_____ Flu_____ TB______
The questions below are personal, but very important to your health care:
Single___, Divorced___, In a relationship___, Married___, Widowed__, Children Y/N How many? ______
Occupation_______________________, for how long________________________________
Tobacco Use per Day (smoking, dipping, e-cig) __________________ Started_____________, Quit______
Alcohol use per Day (beer, wine, mixed drinks) __________________ Street Drugs ___________________
Caffeine use per Day (Soda, coffee, tea) __________________Diet______, Exercise___________________
Do you have a Living Will? **Y/N** Advanced Directive? **Y/N** Durable Medical Power of Attorney? **Y/N**

	Diabetes	**High Blood Pressure**	**Heart Disease**	**Cancer**	**Stroke**
Father					
Mother					
Brother(s)					
Sister(s)					
Grandparents					

Estimate date of your last: Physical Exam___________, Chest X-Ray_________, EKG __________
Pap Smear_________, Colonoscopy___________, Mammogram__________, Prostate Exam________