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 (if you have had one since your last physical):

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

Review of Body Systems

Please check the following boxes for symptoms that are bothersome or you experience frequently.

☐ Severe headaches	☐ Nausea	☐ Painful urination
☐ Nose or throat problems	☐ Trouble swallowing food	☐ Urgency with urination
☐ Shortness of breath	☐ Vomiting blood	☐ Hard to start urine flow
☐ Cough blood	☐ Eye pain	☐ Urinary frequency at night
☐ Wheezing	☐ Numbness	☐ Lose urine control
☐ Chest pain with exercise	☐ Coordination problems	☐ Dark or bloody urine
☐ Joint pains	☐ Stop breathing when asleep	☐ Continuous ringing in the ears
☐ Rapid or irregular heartbeat	☐ Bloody, black, or purple stools	☐ Skin lesions or abnormal moles
☐ Swollen ankles or feet	☐ Diarrhea	☐ Lose balance
☐ Fainting spells	☐ Constipation	☐ Tremors
☐ Falling asleep at work or when driving		☐ Weakness or paralysis

Social Check*: Life is not always easy. We want everyone to be safe and healthy. We're asking about challenges you may be facing and if we may help. Today or in the last year, have you or someone in your household gone without any of the following when it was really needed?

- ☐ Food
- ☐ Housing (including rent or mortgage payment)
- ☐ Utilities (such as electricity, water, internet access, or phone)
- ☐ Feeling safe from physical or emotional harm or other threats
- ☐ Transportation (such as a car or bus fare)
- ☐ Resources for school
- ☐ Dental care
- ☐ Medicine or prescriptions
- ☐ Medical services (such as a doctor or hospital)
- ☐ Mental health services (such as treatment for anxiety or depression)
- ☐ Services for substance abuse (such as drugs or alcohol)
- ☐ Other
- ☐ I'm not experiencing these issues right now.
- ☐ I choose not to answer.

**Social Check was created by IHC and derived from the national PRAPARE® social determinants of health protocol developed by the National Association of Community Health Centers, the Association of Asian Pacific Community Health Organizations, and the Oregon Primary Care Organization and their development partners. www.nachc.org/prapare. ©National Association of Community Health Centers. All Rights Reserved.*

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? _____

Have you had/used any:

vaginal itching/burning/sores?	Yes	No	Describe_____
breast changes?	Yes	No	Describe_____
menopausal symptoms?	Yes	No	Describe_____
birth control?	Yes	No	If so, list_____
sexual problems?	Yes	No	Describe_____
sexually transmitted infections?	Yes	No	If so, list_____
(post-menopause) vaginal bleeding?	Yes	No	Describe_____

Males only:

Have you had any:

Sores or lesions on the penis?	Yes	No	Describe_____
Discharge from the penis?	Yes	No	Describe_____
Pain or swelling in the testicles?	Yes	No	Describe_____
Sexual problems or impotence?	Yes	No	Describe_____
sexually transmitted infections?	Yes	No	If so, list_____