Highland Family Practice
Health History

Name_____ Age_____ Date of Birth_____ Today's Date_____

Occupation_____ Retired? *Yes No*

Sex: *Male Female* Marital Status: *Married to Husband Married to Wife 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	____	Hepatitis C test	____	Mammogram	____
Pneumonia vaccination	____	Shingles vaccination	____	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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Medical Provider Initials: _____

Date: _____

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	_____	_____			
Wheezing	_____	_____	Painful urination	_____	_____
Chest pain with exercise	_____	_____	Urgency with urination	_____	_____
Joint pains	_____	_____	Hard to start urine flow	_____	_____
Rapid or irregular heartbeat	_____	_____	Urinary frequency at night	_____	_____
Swollen ankles or feet	_____	_____			
Fainting spells	_____	_____	Lose urine control	_____	_____
Nausea	_____	_____	Dark or bloody urine	_____	_____
Trouble swallowing food	_____	_____	Continuous ringing in the ears	_____	_____
Vomiting blood	_____	_____			
Skin lesions or abnormal moles	_____	_____	Eye pain	_____	_____
Lose balance	_____	_____	Numbness	_____	_____
Coordination problems	_____	_____	Tremors	_____	_____
Falling asleep at work or when driving	_____	_____	Weakness or paralysis	_____	_____
			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*