Highland Family Practice Health History

Name________________________ Age____ Date of Birth__________ Today's Date_____________

Marital Status: ☐ Married to Husband ☐ Married to Wife ☐ Single ☐ Divorced ☐ Widowed

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

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

Sexual Orientation: ☐ Straight/heterosexual ☐ Lesbian/gay ☐ Bisexual
☐ Queer/pansexual/questioning ☐ Something else

Occupation__________________________ Retired? *Yes No*

Reasons for Exam: ____

Do you take any medications? (Please include directions. Write additional medications at the bottom of the form)

1- ______________________________________ 5- ______________________________________
2- ______________________________________ 6- ______________________________________
3- ______________________________________ 7- ______________________________________
4- ______________________________________ 8- ______________________________________

Medication allergies, sensitivities and intolerances:

1- ________________ 2- ________________ 3- ________________ 4- ________________

	Past Surgery	Year		Past Surgery	Year
1-	____________________	________	4-	____________________	________
2-	____________________	________	5-	____________________	________
3-	____________________	________	6-	____________________	________

	Other Hospitalization	Year		Other Hospitalization	Year
1-	____________________	________	4-	____________________	________
2-	____________________	________	5-	____________________	________
3-	____________________	________	6-	____________________	________

List the year of your last:

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	_____

Patient Name______________________ Date of Birth _______________

Please circle any of the following illnesses and/or medical problems you have or have had:

☐ Anemia	☐ Hernia	☐ Prostate problems	☐ Bleeding problems
☐ Anxiety	☐ Stroke	☐ Endometriosis	☐ High blood pressure
☐ Arthritis	☐ DES exposure	☐ Abnormal Pap	☐ Gallbladder problems
☐ Asthma	☐ Pneumonia	☐ Arteriosclerosis	☐ Stomach/duodenal ulcers
☐ Cancer	☐ AIDS or HIV	☐ Breast problems	☐ Convulsions/seizures
☐ Cataract	☐ Chicken Pox	☐ High cholesterol	☐ Sexually transmitted disease
☐ Colitis	☐ Depression	☐ Kidney stones	☐ Kidney/bladder problems
☐ Diabetes	☐ Diverticulosis	☐ Rheumatic fever	☐ Intravenous drug abuse
☐ Glaucoma	☐ Emphysema	☐ Blood Transfusion	☐ Blood clots in arteries or veins
☐ Gout	☐ Heart attack	☐ Reflux/heartburn	Other:_____________________ ___________________________
☐ Hay fever	☐ Liver trouble	☐ Thyroid problems	
☐ Hepatitis	☐ Tuberculosis	☐ Pelvic inflammation	

Social History

Are you a smoker?	*Yes No*	Packs per day____________ Year started_______
Are you a former smoker?	*Yes No*	Packs/day_____ Year started_____ Year quit_____
Do you drink alcohol?	*Yes No*	Drinks per day, week, or month________________
Are you a recovering alcoholic?	*Yes No*	Year quit ________________________________
Do you use illegal drugs?	*Yes No*	
Do you use your seatbelt regularly?	*Yes No*	
Do you use caffeine?	*Yes No*	Servings per day ___________________________
Do you exercise?	*Yes No*	How many days per week ____________________
If you have guns in your home, are they kept locked up?	*Yes No*	

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

Patient Name________________________ Date of Birth ________________

Your Biological Family History (list all members, even if healthy)

Relation	Sex	Age if living	Age at death	Medical problems/cause of death; write "well" if healthy
Father		_______	_______	____
Mother		_______	_______	____
Siblings (Please specify sex at birth)				
	__	_______	_______	____
	__	_______	_______	____
	__	_______	_______	____
	__	_______	_______	____
	__	_______	_______	____
	__	_______	_______	____
Children (please specify sex at birth)				
	__	_______	_______	____
	__	_______	_______	____
	__	_______	_______	____

If not listed above, please indicate if a child, brother, sister, mother, or father have had:

High blood pressure	__________	Glaucoma	__________	Stroke	__________
Heart Disease	__________	Depression	__________	Diabetes	__________
Cancer	__________	Alcoholism	__________	Tuberculosis	__________
Asthma	__________	Emphysema	__________	Suicide	__________
Blood clots in arteries or veins	__________	Other	____________________________________		

Review of Body Systems

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

☐ Severe headaches
☐ Nose or throat problems
☐ Shortness of breath
☐ Cough blood
☐ Wheezing
☐ Chest pain with exercise
☐ Joint pains
☐ Rapid or irregular heartbeat
☐ Swollen ankles or feet
☐ Fainting spells
☐ Falling asleep at work or when driving

☐ Nausea
☐ Trouble swallowing food
☐ Vomiting blood
☐ Eye pain
☐ Numbness
☐ Coordination problems
☐ Stop breathing when asleep
☐ Constipation
☐ Diarrhea
☐ Bloody, black, or purple stools

☐ Painful urination
☐ Urgency with urination
☐ Hard to start urine flow
☐ Urinary frequency at night
☐ Lose urine control
☐ Dark or bloody urine
☐ Continuous ringing in the ears
☐ Skin lesions or abnormal moles
☐ Lose balance
☐ Tremors
☐ Weakness or paralysis

Patient Name________________________ Date of Birth ________________

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____________________________________