

Highland Family Practice

Health History

Name _____ Age _____ Date of Birth _____ Today's Date _____

Occupation _____ Retired? *Yes No*

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

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

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

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. _____	_____	4. _____	_____	7. _____	_____
2. _____	_____	5. _____	_____	8. _____	_____
3. _____	_____	6. _____	_____	9. _____	_____

Medication allergies, sensitivities and intolerances: _____

Past Surgery	Year	Past Surgery	Year	Past Surgery	Year
1. _____	_____	3. _____	_____	5. _____	_____
2. _____	_____	4. _____	_____	6. _____	_____

Other Hospitalization	Year	Other Hospitalization	Year	Other Hospitalization	Year
1. _____	_____	3. _____	_____	5. _____	_____
2. _____	_____	4. _____	_____	6. _____	_____

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 drink caffeinated drinks? *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*

List the year of your last:

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

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: _____	

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

<u>Relation</u>	<u>Sex</u>	<u>Age, if living</u>	<u>Age at death</u>	<u>Medical problems and/or cause of death; write "well" if healthy</u>
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brothers/Sisters	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
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	_____	_____	Painful urination	_____	_____
Wheezing	_____	_____	Urgency with urination	_____	_____
Chest pain with exercise	_____	_____	Hard to start urine flow	_____	_____
Joint pains	_____	_____	Urinary frequency at night	_____	_____
Rapid or irregular heartbeat	_____	_____	Lose urine control	_____	_____
Swollen ankles or feet	_____	_____	Dark or bloody urine	_____	_____
Fainting spells	_____	_____	Continuous ringing in the ears	_____	_____
Nausea	_____	_____	Eye pain	_____	_____
Trouble swallowing food	_____	_____	Numbness	_____	_____
Vomiting blood	_____	_____	Tremors	_____	_____
Skin lesions or abnormal moles	_____	_____	Weakness or paralysis	_____	_____
Lose balance	_____	_____	Stop breathing when asleep	_____	_____
Coordination problems	_____	_____			
Falling asleep at work or when driving	_____	_____			

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