Grace Health

# Patient History

Name _____ Date _____ Birthdate _____

Do you have an Advance Directive? ❑ Yes ❑ No ❑ Don't Know ❑ Want Information

Past Medical History: *(please check all that apply)*

*Childhood Diseases: ..* ❑ asthma .... ❑ chicken pox..... ❑ measles .... ❑ meningitis .... ❑ mumps ....❑ rheumatic fever

*Adult Illnesses: .....* ❑ asthma .... ❑ bipolar disorder ..... ❑ bronchitis..... ❑cancer ..... ❑ depression/anxiety
❑ diabetes .. ❑ eczema ..... ❑ emphysema ..... ❑ glaucoma.... ❑ heart attack/failure
❑ hepatitis... ❑ high blood pressure .... ❑ high cholesterol.. ❑ HIV ..... ❑ schizophrenia
❑ seizure .... ❑ stroke..... ❑ TB ..... ❑ thyroid disease .....❑ ulcer

*Other* _____

Operations

| Type | When | Where |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Hospitalizations: *(other than the above operations)*

| Type | When | Where |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Current Medications/Over-the-Counter/Vitamins/Herbs: *(if you don't know the name, please indicate why you take them)*

_____

_____

Allergies

Medications _____

Other (food, latex, environmental) _____

Family History

*Father*: ❑ Living – age _____, health problems _____
❑ Deceased – age _____ and cause of death _____

*Mother*: ❑ Living – age _____, health problems _____
❑ Deceased – age _____ and cause of death _____

*Brothers or Sisters*: ❑ Living – age(s) _____, health problems _____
❑ Deceased – age(s) _____ and cause of death _____

Health Maintenance Screening

Last Tetanus shot _____ Last Flu shot _____ Last Pneumonia shot _____

Last Mammogram _____ Colonoscopy/sigmoidoscopy _____ Stool test for blood _____

Last Cholesterol test _____ Exercise: How often _____ Type _____

Number of meals eaten per day _____ Number of dairy servings per day _____

Recent weight gain/loss _____

Do you need help with: ❑ dressing ❑ hygiene ❑ eating ❑ chores ❑ walking ❑ other _____

(over)

General Family History: *(check and write which family member in relationship to you)*

- ❑ Diabetes _____
- ❑ Stroke _____
- ❑ High Blood Pressure _____
- ❑ High Cholesterol _____
- ❑ Heart Disease _____
- ❑ Cancer _____
- ❑ Mental Illness _____

Current Problems: *(please check all that apply)*

*Skin*: ❑ hives ❑ rashes

*Head*: ❑ fainting ❑ severe headaches

*Eye/Ear*: ❑ pain ❑ difficulty seeing/hearing

*Dental, lip or throat*: ❑ dentures ❑ difficulty swallowing

*Heart*: ❑ racing ❑ heart murmur ❑ severe chest pains

*Lung*: ❑ chronic cough ❑ difficulty breathing ❑ cough up phlegm/blood ❑ abnormal chest x-ray

*Breast:* ❑ lumps ❑ pain ❑ discharge

*Gastro-intestinal*: ❑ nausea ❑ constipation ❑ stomach pains/bloating ❑ vomited blood
❑ rectal bleeding ❑ loose/black stools

*Urinary*: ❑ bloody urine ❑ penis discharge ❑ problem with erection
❑ frequent/burning with urination ❑ difficulty starting/leaking urine

*Blood*: ❑ clotting ❑ abnormal bleeding

*Muscle, Bone, Joint*: ❑ pain ❑ swelling

*Mental Health*: ❑ nervousness ❑ problem sleeping ❑ hearing voices ❑ seeing things
❑ sadness ❑ thoughts of hurting myself or someone else ❑ drug or alcohol abuse

*Other* _____

Sexual: Are you in a sexual relationship? ❑ Yes ❑ No Partner: ❑ Male ❑ female
How long with current partner(s) _____
How many sex partners have you had in your life _____
Bleeding/Pain after sexual relations? ❑ Yes ❑ No
Are you satisfied with your sex life? ❑ Yes ❑ No

Female Only
First day of last period _____ Cramping before or with period _____
Days between periods _____ Length of periods _____
Pass clots with period? ❑ Yes ❑ No Last pelvic exam/Pap smear _____
Method of birth control _____ How long on birth control _____
Itching in vaginal area? ❑ Yes ❑ No Unpleasant odor? ❑ Yes ❑ No
Any abnormal Pap smear results? ❑ Yes ❑ No
Number of: Pregnancies _____ Births _____ Miscarriages _____ Abortions _____
Do you do a self-breast exam monthly? ❑ Yes ❑ No

Male Only
Do you do a self-testicular exam monthly? ❑ Yes ❑ No
If over 40 years of age, have you had a prostate test or exam done? ❑ Yes ❑ No

Social History ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single
Occupation _____
Who do you live with _____
Do you feel safe in your home? ❑ Yes ❑ No Are you afraid of anyone _____
Is there a gun in your home? ❑ Yes ❑ No If so, is the gun locked when not in use? ❑ Yes ❑ No
Has anyone ever threatened/hit/pushed/abused you _____
Have you ever been forced to have sex/do something sexual you didn't want to do - ❑ Yes ❑ No
Smoke - ❑ Yes ❑ No How much _____ How long _____
Drink - ❑ Yes ❑ No How much _____ How long _____
Marijuana/cocaine/other - Yes ❑ No ❑ How often _____ How long _____