Health History

Providence Seaside Hospital

Please fill out this health history form as best you can:

Name:_______________ **Date of Birth:**_______________

______ **Name you like to be called:** _______________

____

Prior Provider: _______________ **Last Seen:** _______________

Prior Provider Phone Number: _______________ **Location:** _______________

Gender: ☐ Male ☐ Female ☐ Other

GENERAL

1. Are you: ☐ Single ☐ Married ☐ Partnered ☐ Divorced/Separated ☐ Other _________
2. Where did you grow up? _______________
3. What kind of work do you do or, if retired, what did you do? _______________
4. What level of education did you complete? _______________

Please check the **conditions** you have: □ **No conditions**

☐ Anemia
☐ Problems with anesthesia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Blood transfusion
☐ Cancer: _______________
☐ Cataracts
☐ Heart failure
☐ Clotting disorder
☐ COPD
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Allergies, seasonal
☐ GERD or heartburn
☐ Heart murmur
☐ Hepatitis A, B, C
☐ HIV or AIDS
☐ High cholesterol
☐ High blood pressure
☐ Kidney problems
☐ Meningitis
☐ Heart attack
☐ Nerve or muscle problems
☐ Osteoporosis
☐ Seizures
☐ Sickle cell anemia
☐ Stroke
☐ Substance abuse
☐ Thyroid disease
☐ Tuberculosis or TB
☐ Other: _______________

Please check the **surgeries** you have had and write the **date** you had it: □ **No surgery**

☐ Appendix
☐ Gallbladder
☐ Hernia
☐ Hysterectomy
Reason: _______________
☐ Biopsy of: _______________
☐ Joint replacement of:
____
☐ Mastectomy
☐ Ovaries removed
☐ Tonsils
☐ Other: _______________
☐ Other: _______________
☐ Other: _______________
☐ Other: _______________

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Please list any **allergies** you have: ☐ **No allergies**

ALLERIGIC TO:	WHAT HAPPENS:

Please list the **medications, vitamins,** and **supplements** you take:

NAME	DOSE	HOW DO YOU TAKE THE MEDICATIONS?

Name and location of the **pharmacy** you use: ____________________

☐ I would like a 90-day prescription

****Bring all medications with you to your appointment; prescription and over the counter****

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Do you have an **Advance Directive**?

☐ Yes, please bring a copy with you to your appointment.

☐ No

Do you have a **POLST**?

☐ Yes, please bring a copy with you to your appointment.

☐ No

Let us know how **you are feeling today**:

Over the past 2 weeks, how often have you been bothered by:	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

PHQ9

Do you see a mental health professional? ☐ Yes ☐ No If yes, who? ______________________________

Do you use or have you ever used **cigarettes, cigars, pipe, vape, snuff or chewing tobacco**? ☐ Yes ☐ No

- If you no longer use tobacco, what year did you quit? ________
- How many packs of cigarettes per day did/do you smoke? _________
- How many cans per day did/do you chew? __________
- If you currently smoke and/or chew, do you want to quit? __________________
- Are you currently using drugs? ☐ No ☐ Yes If yes, types of drugs used: *check all the apply*

  ☐Marijuana ☐ Methamphetamines ☐ Cocaine ☐ Heroin ☐ Other __________________________
- Have you abused drugs in your past? ______
- How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons? ☐ None or ☐ 1 or more

DAST

- For **men**: How many times in the past year have you had 5 or more drinks in a day? ☐None or☐1 or more
- For **women**: How many times in the past year have you had 4 or more drinks in a day? ☐None or ☐1 or more

AUDIT

Do you have sex with ☐ Men ☐ Women ☐ Both ☐ I Don't Have Sex

If you use birth control, what type do you use? *Check all that apply*

☐ Abstinence ☐ Rhythm (calendar tracking) ☐ Inserts ☐ Implant ☐ Condom

☐ Tubal Ligation (tubes tided) ☐ IUD ☐ Vasectomy ☐ Injection ☐ Withdrawal/Pullout

☐Birth Control Pills ☐ Diaphragm ☐ Post-menopausal ☐ Other ______________________________

Do you exercise 2 or more days a week? ☐ Yes ☐ No

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Please let us know about your **preventive health services:**

- What was the date of your last colonoscopy?____________Where was it done? ________________________
- What was the date of your last eye exam?__________Who is your eye care provider? _____________
- Please let us know the names of other providers or doctors who are part of your health care:

  Name:____Specialty:____________________________
  Name:____Specialty:____________________________
  Name:____Specialty: ____________________________

- For **men** only: what was the date of your last:
  - Prostate exam and PSA testing: __________________________________
- For **women** only: what was the date of your last:
  - Menstrual period: ____________
  - PAP Smear: __________________ History of abnormal PAP? ☐ Yes ☐ No
  - Mammogram: _______________
  - Bone Density Study: __________

- **Immunizations (Shots):**

☐ Flu Date _______________ Where given ___________________________
☐ Tetanus-Diptheria (Td) Date _______________Where given ___________________________
☐ Tetanus-Diptheria-Pertussis (Tdap) Date _______________ Where given ___________________________
☐ HPV (Gardasil) Date _______________ Where given ___________________________
☐ Pneumovax (Pneumonia) Date _______________ Where given ___________________________
☐ Prevnar (Pneumonia) Date _______________ Where given ___________________________
☐ Zostavax (Shingles) Date _______________ Where given ___________________________
☐ Shingrix (Shingles) Date _______________ Where given ___________________________
☐ Hepatitis A Date _______________ Where given ___________________________
☐ Hepatitis B Date _______________ Where given ___________________________
☐ MMR (Measles-Mumps-Rubella) Date _______________ Where given ___________________________
☐ Varicella (Chickenpox) Date _______________ Where given ___________________________
☐ Other ________________________ Date _______________ Where given ___________________________
☐ Other ________________________ Date _______________ Where given ___________________________
☐ Other ________________________ Date _______________ Where given ___________________________

Please check any **family history of cancer:**

☐ Bladder
☐ Brain
☐ Breast
☐ Cervical
☐ Colon or Rectal
☐ Kidney
☐ Lung
☐ Melanoma
☐ Non-Hodgkin Lymphoma
☐ Ovarian
☐ Pancreatic
☐ Prostate
☐ Small Bowel
☐ Stomach
☐ Thyroid
☐ Uterine or Endometrial
☐ Other: ___________
☐ Other: __________

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Has anyone in your family had genetic testing? ☐ Yes ☐ No

Please let us know about your family's health history:

Name	Age or Deceased	Health Problems
Father:		
Mother:		
Brother: 1. ____ 2. ____ 3. ____ 4. ____	____ ____ ____ ____	____ ____ ____ ____
Sister: 1. ____ 2. ____ 3. ____ 4. ____	____ ____ ____ ____	____ ____ ____ ____
Grandfathers: Father side: ____ ____ Mother side: ____ ____	____ ____ ____ ____	____ ____ ____ ____
Grandmothers: Father side: ____ ____ Mother side: ____ ____	____ ____ ____ ____	____ ____ ____ ____
Aunts: Father side: ____ ____ Mother side: ____ ____	____ ____ ____ ____	____ ____ ____ ____
Uncles: Father side: ____ ____ Mother side: ____ ____	____ ____ ____ ____	____ ____ ____ ____
Children: 1. ____ 2. ____ 3. ____ 4. ____ 5. ____	____ ____ ____ ____ ____	____ ____ ____ ____ ____

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Please let us know how you are **feeling** today: ☐ **No symptoms below**

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Sweats
- ☐ Weakness
- ☐ Weight loss / gain

Skin
- ☐ Change in mole
- ☐ Itching
- ☐ Rash

Ear, Nose, Throat
- ☐ Congestion
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Ear ringing
- ☐ Headaches
- ☐ Hearing loss
- ☐ Nosebleeds

Eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Eye redness
- ☐ Light sensitivity
- ☐ Last eye exam (where/when): ________________

Home
- ☐ Not enough food
- ☐ Financial stress
- ☐ Unsafe relationship

Cardiac
- ☐ Chest pain
- ☐ Leg pain when walking
- ☐ Leg/ankle swelling
- ☐ Palpitations
- ☐ Short of breath when lying down
- ☐ Waking up short of breath

Respiratory
- ☐ Bloody sputum
- ☐ Cough
- ☐ Short of breath
- ☐ Sputum production
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal pain
- ☐ Black stool
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

Genitourinary
- ☐ Blood in urine
- ☐ Flank pain
- ☐ Frequent urination
- ☐ Leaking urine
- ☐ Nighttime urination
- ☐ Painful urination
- ☐ Urgent urination

Musculoskeletal
- ☐ Back pain
- ☐ Falls
- ☐ Joint pain
- ☐ Muscle aches
- ☐ Neck pain

Hematology
- ☐ Allergies
- ☐ Easy bruising or bleeding
- ☐ Unusual thirst

Neurological
- ☐ Dizziness
- ☐ Loss of Consciousness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech change
- ☐ Tingling
- ☐ Tremor
- ☐ Weakness

Psychiatric
- ☐ Anxiety
- ☐ Daytime sleepiness
- ☐ Don't feel safe
- ☐ Hallucinations
- ☐ Memory loss
- ☐ Suicidal ideas
- ☐ Trouble sleeping

Anything else we should know?