HEALTH HISTORY

U.P. North Family Medicine DPC, PLLC

Full Name:

INTRODUCTION:

How would you describe your health?

What is your most concerning health problem?

What measures have you taken so far to address it (treatments, medications, specialists seen)?

What are your goals for your first visit?

What are your health goals for the next month?

What are your health goals for the next year?

What do you think is important for me to know about you?

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MEDICATIONS: Please list all prescription and nonprescription (over the counter) medications, as well as any supplements. You may include this on a separate sheet of paper if you have a pre-printed list.

Drug Name	Dose (mg or ?)	How often (daily, twice daily?)	For what?

What challenges do you face with your medications (Cost, availability, etc.)?

PAST MEDICATIONS: Are there any medications you have taken in the past? Why were they stopped?

ALLERGIES: Please list medication allergies, and your reaction. Also list food or environmental allergies.

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MEDICAL HISTORY: Please list all medical problems, including conditions that have resolved or are controlled with medications (i.e. high blood pressure). Please include the approximate date it began. Examples may include: high cholesterol, diabetes, cancer, heart attack, stroke, etc.

SURGICAL HISTORY: Please list surgeries you have had, date, hospital, and name of the surgeon (if known).

HOSPITALIZATIONS: Please list any times other than surgery you have stayed overnight in the hospital, the date, reason, and which hospital.

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REPRODUCTIVE/SEXUAL HEALTH HISTORY:

For Women:

At what age did you begin periods? Are you still having periods?

How frequent are your periods? Do you have any concerns regarding your periods?

Have you had pregnancies/abortions/miscarriages?

For Men:

Have you had any penile/testicular conditions?

All sexes:

Are you currently sexually active?

Do you take any steps to prevent pregnancy or disease?

Do you have any concerns with intercourse?

Do you have any questions or concern about your gender identity?

In your intimate relationships, do you favor partners who are male, female, or those who might identify otherwise?

What questions do you have about your sexual health?

Do you think you are at risk for HIV or other sexually transmitted infections?

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SOCIAL HISTORY:

Where were you born?

Where did you grow up?

What is your race/ethnicity?

What is your first language?

How much schooling have you completed (high school, college, grad school)?

What type of work have you done or do you do?

Can you describe your relationship or marriage history?

Do you have children, and if so, what are their names and ages?

Describe what you do in your free time.

Do you have a spiritual or religious practice?

Is there a specific clergy person you would want to be involved in or aware of your care if you were hospitalized?

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RECREATIONAL DRUG USE:

Do you smoke (how many packs per day, year started & year quit)?

How much alcohol do you drink per day?

Do you drink caffeine? How much per day?

Do you use, or have you used, marijuana for recreation or medicinal purposes?

Have you used any other types of recreational/illicit drugs?

PSYCHIATRIC HISTORY:

What are your stressors?

What do you do to relieve stress?

Do you feel depressed or anxious?

Have you ever been formally diagnosed with any mental health condition, or been in the care of a psychiatrist in a clinic or in the hospital?

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DIET:

What dietary and nutritional goals do you have?

What questions do you have about your diet?

What kinds of foods do you usually eat for breakfast, lunch, or dinner? Do you avoid any specific foods? Why?

Do you have any food insecurity (affording, obtaining) concerns?

ACTIVITY:

What kinds of exercise or physical activity do you do?

How often and for how long do you exercise in a week?

Are you satisfied with your level of physical activity? If not, what would you like to be able to do?

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SLEEP HISTORY:

How many hours per night do you sleep?

Are you satisfied with how well or how long you sleep?

How often do you wake up in the night?

What questions do you have about sleep?

FAMILY HISTORY: Please note your first-degree family members (parent, sibling, child) and any health conditions they have/had. Also note if there are any health conditions which have occurred in multiple family members (cousins, aunts, uncles, grandparents). Examples: Cancer (what kind?), heart attack, stroke, high blood pressure, diabetes, high cholesterol, blood disorders, anxiety/depression/bipolar, etc.

Condition	Family Member	Age diagnosed

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HEALTH MAINTENANCE:
Please note if you have completed the following tests, important results/details and the approximate date:
Bone Density Scan

Eye Exam

Dental Exam

Hearing Exam

EKG

Colonoscopy

Sleep study

Pulmonary Function Test

Echocardiogram

Lung cancer screening for smokers (CT scan)

Abdominal Aortic Aneurysm screening for smokers (ultrasound)

PSA (prostate lab test) (males)

Mammogram (females)

Pap Smear (females, please list any abnormal results and follow up testing)

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SAFETY CONCERNS:

Do you always wear a seat belt when you drive? ☐Yes ☐No

Do you always wear a bike helmet? ☐Yes ☐No

Do you keep firearms in your home? ☐Yes ☐No

If so, are they stored in a locked place? ☐Yes ☐No

Do you have working smoke detectors? ☐Yes ☐No

Do you have a working carbon monoxide detector? ☐Yes ☐No

Is there anyone currently in your life now who says abusive things to you? ☐Yes ☐No

Is there anyone currently in your life now who has physically harmed you? ☐Yes ☐No

Is there anyone in your past who said abusive things to you? ☐Yes ☐No

Is there anyone in your past who physically harmed you? ☐Yes ☐No

Is there anyone using your money without your permission? ☐Yes ☐No

Do you have problems with walking or falls? ☐Yes ☐No

Do you or anyone in your life have concerns about your ability to drive safely? ☐Yes ☐No

FUNCTIONAL HISTORY:

Do you need help with any of the following: transferring from a bed to a chair, walking, or travelling by car; upper or lower body dressing or bathing; buying food, making meals, or feeding yourself; managing your medications or finances?

Do you have any problems with bowel or bladder control?

Do you use any medical equipment at home (CPAP, oxygen, walker, wheelchair, glucometer, TENS, etc.)?

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EXPOSURE HISTORY: Have you ever been exposed to chemicals, irritants, or pollutants in the past? Examples: Lead-based paint, water-damaged building with mold, living in an area exposed to pesticides or radiation, or working in a place with chemicals, animals, or radiation.

ADVANCE DIRECTIVES:

Do you have an advance directive? (If so, please bring a copy for your electronic medical record)

Do you have a Medical Durable Power of Attorney (DPOA)? (If so, please bring a copy for your electronic medical record)

What questions do you have about advance directives or DPOA?

Would you like resources to help you set up an advance directive or designate a DPOA?

CARE PROVIDERS: Please list any medical/healthcare professionals involved in your care, including doctors, dentists, eye doctors, massage therapists, chiropractors, specialists, etc. (Please include a phone number and fax number when possible.)