Northwest Family Medicine

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HEALTH HISTORY AGES 18 AND OLDER

Please take the time to fill out this confidential form to the best of your ability so that we may better serve you. Thank you.

Legal Name _____ Today's Date _____

Date of birth _____ Age _____

What is your reason for this visit? _____

ALLERGIES (*include food and drug allergies*):

Date	Medication/Allergen	Your Reaction

MEDICATIONS (*list current medications and doses*):

PAST MEDICAL HISTORY

Date of onset	Chronic Problems

SURGERIES/HOSPITALIZATIONS

Date	Type of Surgery/Nature of Hospitalization

SYMPTOMS (*check yes or no regarding the following symptoms in the past week*):

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Fatigue	☐	☐	Chest pain	☐	☐	Pain with urination	☐	☐	Itching
☐	☐	Fever	☐	☐	Irregular heart beat	☐	☐	Blood in urine	☐	☐	Rash
☐	☐	Night sweats	☐	☐	Leg cramps with walking	☐	☐	Too cold	☐	☐	Bone/joint pain
☐	☐	Visual changes	☐	☐	Abdominal pain	☐	☐	Too hot	☐	☐	Muscle weakness
☐	☐	Eye discharge	☐	☐	Constipation	☐	☐	Increased thirst	☐	☐	Off balance
☐	☐	Ear discharge	☐	☐	Diarrhea	☐	☐	Increased hunger	☐	☐	Easy bruising or bleeding
☐	☐	Hearing loss	☐	☐	Vomiting	☐	☐	Increased urination	☐	☐	Hay fever
☐	☐	Nasal drainage				☐	☐	Depressed	☐	☐	Food allergy
☐	☐	Cough				☐	☐	Anxious			
☐	☐	Wheezing or short of breath									

NAME_____ **Date of birth**_____

SOCIAL HISTORY

Level of education completed		Occupation	
Degree		Occupational Hazards	

Do you smoke tobacco?		How much alcohol do you drink?	
How much per day do you smoke?		Are you married, single, divorced, widowed, other?	
For how many years?		Do you have a religious affiliation or spiritual beliefs?	*Yes* *No*
Have you ever tried to quit?		Is this an important part of your life?	*Yes* *No*

Do you have advance directives in place (*check one*)?

☐ None ☐ Living will ☐ Healthcare by proxy
☐ DNR ☐ Durable power of attorney

FAMILY HISTORY

Medical Problem	Family Member	Current Age	Age of Death	Cause of Death

HEALTH MAINTENANCE (*please give approximate dates*)

Last Physical Exam		Last Pap Smear		Influenza Vaccine	
Last Lipid Panel		Mammogram		Pneumococcal Vaccine	
Colonoscopy		Bone Density Scan		Tetanus Vaccine	

WOMEN'S HEALTH HISTORY

Age when periods started		Are you currently pregnant?	
Age when first child was born		Are you postmenopausal?	
Date of last menstrual period		Age of menopause	

PREGNANCY HISTORY *(please include all abortions, miscarriages, or adoptions)*

Year of Birth	Boy or Girl?	Weight	Vaginal or C-Section?	Complications