Foothills Health and Wellness Center

Health History Form

Today's date: _____ /_____ /_____

Name: _____ Date of birth: _____ /_____ /_____ Gender: □ Male □ Female

Previous Primary Care Physician (if any): _____

Other physicians or providers involved in your care: _____

_____

Reason for today's visit: _____

Medications currently taking and dosage: (or provide list)
Please include supplements and over-the-counter medications.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies (medications, foods, etc.): □ None

_____ _____

_____ _____

Surgeries: please list any surgeries that you have had and the date (some common ones are gallbladder, appendix, tonsils, hysterectomy, hernia, C-section)

Date	Procedure
_____	_____
_____	_____
_____	_____
_____	_____

OFFICE USE ONLY:
HISTORIES □ COMPLETED

Medical History: What problems or conditions have you been diagnosed with or treated for in the past?

□ Stroke _____
□ Seizures _____
□ Thyroid disease _____
□ Cancer _____
□ Glaucoma _____
□ High blood pressure _____
□ Blood clots _____
□ Migraines _____
□ Heart burn, reflux _____
□ Stomach or GI ulcers or bleeding _____
□ Heart disease _____
□ Heart arrhythmia _____
□ Heart valve problem _____
□ High cholesterol _____
□ Hepatitis B or C _____
□ HIV / AIDS _____
□ Kidney stones _____
□ COPD or emphysema _____
□ Asthma _____
□ Depression _____
□ Bipolar disorder _____
□ Anxiety _____
□ Substance abuse _____
□ Arthritis _____
□ Osteoporosis _____
□ Diabetes _____

Communication:

□ Deaf_____
□ Hard of hearing, left ear_____
□ Hard of hearing, right ear _____
□ Interpreter Required _____
□ Legally blind_____
□ Mute _____
□ Visually Impaired _____

Social / Family/ Culture:

Work: □ Employed □ Not employed □ Retired □ Disabled

Marital status: □ Single □ Married □ Divorced □ Separated □ Widowed

Children and ages: _____

How often do you drink alcohol? _____ □ Never

Tobacco use: □ Never □ Currently □ Quit – when? _____

□ Chew □ Smoke How many packs per day? _____ How many years? _____

Do you use recreational drugs? □ No □ Yes – what kind? _____

Do you use pills other than as prescribed or take someone else's pills? _____

Do you exercise? □ No □ Yes – what do you do and how often? _____

Do you always wear a seatbelt? □ No □ Yes

Do you have an Advanced Directive such as a power of attorney, living will etc.? □ No □ Yes

_____

Preferred hospital: _____

What race or ethnicity do you consider yourself? _____

Gender identity: □ Male □ Female □ Female to Male □ Male to Female □ Gender queer □ Other

Sexual Orientation: □ Straight/heterosexual □ Lesbian, gay or homosexual □ bisexual □ something else

□ Don't know

Do you have any Religious Affiliations? _____

Staff to complete Social Determinants of Health Assessment.

Family History: Is there any cancer, heart disease, diabetes, mental illness, substance abuse, birth defects, neurological disease, kidney disease, blood disorders, blood clots, stroke, or other conditions in family members?

Mother □ Living □ Deceased (age ____) Medical problems: _____

Father □ Living □ Deceased (age ____) Medical problems: _____

Sibling(s) medical problems: _____

Other family history: _____

□ Adopted / unknown _____

Health Maintenance:

Have you had a pneumonia shot? □ No □ Don't know □ Yes - when? _____

Do you take flu shots? □ Yes □ No Last one: _____

When was your last tetanus shot? _____

Have you had a colonoscopy or other test for colon cancer? □ No □ Yes - when? _____

Have you been tested for Hepatitis C? □ No □ Yes - when? _____

Have you had a shingles shot (if age over 60)? □ No □ Yes - when? _____

Women ONLY:

Last Pap test: _____ □ Never
Have you ever had an abnormal Pap test?
□ No □ Yes
Number of pregnancies: _____
Last mammogram: _____ □ Never
Last bone density test: _____ □ Never
Date of last menstrual cycle: _____

Men ONLY:

Last prostate test or exam: _____ □ Never

Have you been screened for an aortic aneurysm (called AAA) if smoker and age 65-75? □ Yes □ No

Is there anything else we need to know about you to provide the best care possible? _____

_____

Thank You!