Catherine's HEALTH CENTER

Health History Form

Please complete the following form to the best of your ability. **Your answers are for our records only and will be kept confidential.** Your answers will help your provider better understand your medical concerns. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important.

Full Legal Name of Patient _____ Patient Date of Birth (MM/DD/YYYY) _____

Full Legal Name of person filling out form (*Skip if patient is filling out form*) _____ Relationship to Patient _____

Main reason for today's visit:
Other concerns:

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

Allergy	Reaction	Allergy	Reaction
1.		3.	
2.		4.	

Your preferred Pharmacy: _____ Address: _____

Please list all the medications you are currently taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please Check All That Apply to Your Past Medical History

- ☐ ADHD
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma - Reactive airway disease
- ☐ Bleeding Disorder
- ☐ Blood clots (or DVT)
- ☐ Broken Bone
- ☐ Cancer
- ☐ Coronary Artery Disease
- ☐ Claustrophobia
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Dialysis
- ☐ Diverticulitis
- ☐ Eczema or Psoriasis
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Has Pacemaker
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hiatal Hernia
- ☐ HIV or AIDs
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ OCD
- ☐ ODD
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Learning Disability
- ☐ Leg/Foot Ulcers
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Pulmonary Embolism
- ☐ Recurrent wheezing
- ☐ Recurrent ear infections
- ☐ Recurrent UTIs
- ☐ Reflux or Ulcers
- ☐ Seizure Disorder
- ☐ Schizophrenia
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other _____

If known, who was your past Primary Care Physician or Pediatrician before coming to Catherine's:

Past Surgical History

SURGERY	REASON	YEAR	HOSPITAL
1.			
2.			
3.			
4.			

Obstetric and Gynecological History, if Applicable

Last Pap Smear Date: _____ ☐ Abnormal
Last Mammogram Date: _____ ☐ Abnormal
Number of pregnancies: _____
Number of miscarriages: _____
Cesarean sections (yes/no): _____

Age of first menstrual period: _____
Date of last menstrual period or age of menopause: _____
Number of births: _____
Number of abortions: _____
If yes, number of cesarean sections: _____

Family Health History

RELATION	ALIVE? (Y/N)	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Grandfather (paternal)			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Father			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Mother			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Brother/Sister			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke
Other: _____			☐ Alcoholism ☐ Arthritis ☐ Depression ☐ Cancer ☐ Diabetes ☐ Genetic disease ☐ Heart disease ☐ Hypertension ☐ Osteoporosis ☐ Stroke

Social Health History

Please check below all that apply to your tobacco, alcohol, and caffeine intake, if any:

Tobacco intake:

☐ Never smoked ☐ Former smoker ☐ Current smoker ☐ Decline to answer Years of tobacco use: _____

☐ 1 pack/week ☐ 2 packs/week ☐ 1/4 pack/day ☐ 1/2 pack/day ☐ 1 pack/day ☐ 1 1/2 packs/day ☐ 2 packs/day ☐ 3+ packs/day

☐ Never used smokeless tobacco ☐ Former smokeless tobacco user ☐ Current snuff user ☐ Currently chews tobacco ☐ Currently uses moist powdered tobacco ☐ Decline to answer

☐ Never used electronic cigarettes ☐ Former user of electronic cigarettes ☐ Current user of electronic cigarettes ☐ Decline to answer

Caffeine intake: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Alcohol intake: ☐ Yes ☐ No **If yes, how many drinks/week?** _____

Do you use any illicit or recreational drugs? ☐ Yes ☐ No **Which kind?** _____

Are you currently employed? ☐ Yes ☐ No **Occupation:** _____

Level of Education Achieved: ☐ Grade School ☐ High School/GED ☐ Trade School ☐ College ☐ Graduate ☐ Post-graduate

	Yes	No
Are you able to care for yourself?		
Are you legally blind in one or both eyes?		

	Yes	No
Are you hard of hearing or deaf in one or both ears?		

Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐ Domestic Partner

Please check below all that apply to you:

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Diet: ☐ Regular ☐ Vegetarian ☐ Diabetic ☐ Gluten Free ☐ Specific ☐ Cardiac

Sexually Active? ☐ Yes ☐ No

Do you use an advanced directive? ☐ Yes ☐ No

Pediatric Social Health History (For Pediatric Patients Only)

Birth History

Hospital where patient was born: _____
Weeks gestation: _____
Birth weight: _____

Complications with pregnancy: _____
Complications with delivery: _____
Extended hospital stay after delivery/neonatal concerns: _____

Type of Housing ☐ House (owned) ☐ House (rent) ☐ Apartment ☐ Shelter ☐ Doubling up ☐ Homeless

Who lives in the home? ☐ Mom ☐ Dad ☐ Siblings # _____ ☐ Grandparents ☐ Others _____

Relationship Status of Parents: _____ **Employment Status of Parents:** _____

Daycare/School patient attends: _____ **# of Pets at Home** _____ **# of Smokers at Home** _____

Substances used at home (marijuana, alcohol, illicit substances): _____

Are there smoke detectors and carbon monoxide detectors in the home? ☐ Yes ☐ No **Are there firearms in the home?** ☐ Yes ☐ No

Drinking water source ☐ City ☐ Well ☐ Bottled **Does the family receive financial assistance (WIC, SNAP, etc)?** ☐ Yes ☐ No

Dental Information

Are you under the care of a dental provider? ☐ Yes ☐ No ☐ DK

If yes, and NOT at Catherine's Health Center, please provide the following information:

Provider Name:	Phone Number:		
Street Address:	City:	State:	Zip

Would you like information about dental services provided by Catherine's? ☐ Yes ☐ No

Date of last dental exam: _____

Please check DK if you do not know the answers to any question.

☐ Yes ☐ No ☐ DK **Do your gums bleed when you brush or floss?**

☐ Yes ☐ No ☐ DK **Are your teeth sensitive to cold, hot, sweets, or pressure?**

☐ Yes ☐ No ☐ DK **Does food or floss catch between your teeth?**

☐ Yes ☐ No ☐ DK **Is your mouth dry?**

☐ Yes ☐ No ☐ DK **Have you ever had any gum treatments?**

☐ Yes ☐ No ☐ DK **Have you ever had braces or other orthodontic treatment?**

☐ Yes ☐ No ☐ DK **Have you ever had any problems associated with previous dental treatment?**

☐ Yes ☐ No ☐ DK **Does your water at home have fluoride?**

☐ Yes ☐ No ☐ DK **Are you currently experiencing dental pain or discomfort?**

☐ Yes ☐ No ☐ DK **Do you have earaches or neck pains?**

☐ Yes ☐ No ☐ DK **Do you have any clicking, popping, or discomfort in the jaw?**

☐ Yes ☐ No ☐ DK **Do you grind or brux your teeth?**

☐ Yes ☐ No ☐ DK **Do you have sores or ulcers in your mouth?**

☐ Yes ☐ No ☐ DK **Do you wear dentures or partials?**

☐ Yes ☐ No ☐ DK **Do you participate in active recreational activities?**

☐ Yes ☐ No ☐ DK **Have you ever had a serious injury to your head or mouth?**

☐ Yes ☐ No ☐ DK **Do you drink bottled or filtered water?**

☐ Daily ☐ Weekly ☐ Occasionally **If yes, how often?**