Duluth Family Medicine Clinic

Patient Label

Patient Health History Form

Patient Name: ______________________________________ **DOB:** _____________ **Today's Date** ___________

Sex (assigned at birth): ☐ Male ☐ Female ☐ Intersex

Gender: ☐ Male ☐ Female ☐ Transgender masculine ☐ Transgender feminine ☐ Gender non-binary

☐ Other _____________ ☐ Prefer not to answer

Where were you getting your care before? ____

Any other current physical or mental health specialists, therapists, or other care providers: ____________________

____

How did you hear about us?______________________ **Who referred you to our clinic?**______________________________

MY MEDICAL HISTORY: Check all that apply

Diagnosis	Current	Past	Diagnosis	Current	Past	Diagnosis	Current	Past
Addiction			Hernia			Cancer		
Anemia or Bleeding			High cholesterol			Cardiovascular or heart disease		
Blood clots			Osteoporosis or osteopenia			Gastrointestinal disease (gut, bowel)		
Depression			HIV or AIDS			Genetic disease		
Anxiety			Immune deficiency			Kidney disease		
Psychiatric/Mental Illness			Skin disorder			Neurological disease		
Diabetes			Breast problems			Hepatitis		
High blood pressure			Urinary or bladder problems			Insomnia or sleep difficulty		
Allergies or Asthma			Dental problems			Headaches		
COPD or emphysema			Joint problems			Glaucoma		
Thyroid or endocrine disease			Spine or back problems			Cataracts		
Aneurysm			Circulation problems			Gout		
Autoimmune disease			Stroke			Other (list below)		

Please list any additional health problems not listed above, or any additional comments related to the above diagnoses:

____

____

FEMALE: Age at first period: ______ Start of last period: ______ ☐ Menopause (year: ____) Prior pregnancy? ☐ No ☐ Yes (see below)

Total number of -- Pregnancies: #______ Births: #______ Miscarriages: #______ Abortions #______

Date of last Pap smear: _______ History of an abnormal pap? ☐ No ☐ Yes History of a colposcopy or LEEP? ☐ No ☐ Yes

Date of last mammogram: ___________ History of an abnormal mammogram? ☐ No ☐ Yes

MALE: History of prostate disease or problems? ☐ No ☐ Yes Date of last PSA test or prostate exam: _______

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. ☐ **No Medications**

Medication Dose Times per day | Medication Dose Times per day | Medication Dose Times per day

1. ______________________ 5. ______________________ 9. ______________________
2. ______________________ 6. ______________________ 10. ______________________
3. ______________________ 7. ______________________ 11. ______________________
4. ______________________ 8. ______________________ 12. ______________________

ALLERGIES or intolerance to medications (include reaction type): ☐ **No Known Allergies**

IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. ☐
Tetanus (Td) ______ With Pertussis (Tdap) _______ Varicella (Chicken Pox) shot *or* illness ______ Pneumovax (pneumonia) _____
Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____ Meningitis _____ Zostavax (shingles) _____ HPV _____

Please Complete Other Side of Form

SURGICAL HISTORY:

Surgery Date
- ☐ Abdominal surgery __________
- ☐ Appendectomy __________
- ☐ Back surgery __________
- ☐ Neck surgery __________
- ☐ Biopsy (location?) __________
- ☐ Colonoscopy __________
- ☐ Heart surgery or stent __________
- ☐ EGD/Upper endoscopy __________
- ☐ Gallbladder removal __________
- ☐ Hip or knee surgery __________
- ☐ Joint replacement __________
- ☐ Wisdom Teeth __________
- ☐ Tonsils or Adenoids __________
- ☐ Other (please list below:)

____
____
____
____

FAMILY HISTORY: ☐ Adopted ☐ Family History Unknown

Please place a check mark in the appropriate box if a family members has had any of the following problems:	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Daughter(s)	Son(s)	Comments
Addiction											
Allergies/Asthma											
Aneurysm											
Autoimmune disease											
Cancer											
Cardiovascular/ Heart disease											
Clotting/bleeding problems											
Dementia											
Diabetes											
Gastrointestinal disease (gut, bowel)											
Genetic disease											
High blood pressure											
Psychiatric/ Mental illness											
Kidney disease											
Neurological disease											
Stroke											
Thyroid or endocrine disease											
Other											

Do you have any screws, plates, nails, fusions? ☐ No ☐ Yes _______________

SOCIAL HISTORY:
Occupation (or prior occupation): ________________________________ retired / unemployed / leave of absence / disabled (circle one)
Employer: _______________________ Years of education or highest degree: ___________ Disability diagnosis: ____________________
Marital status (circle one): single, partner, married, divorced, widowed, other: __________________ Number of children: ________
Living situation: ☐ Homeless ☐ Assisted living ☐ Nursing Home ☐ Apartment ☐ House ☐ Other ________________
Who lives with you? _______________________________________ Do you feel unsafe or at risk for violence in your home? ☐ Yes ☐ No

HEALTH HABITS:
Do you now use or have you ever used in the past:
- Tobacco: ☐ Cigarettes or Cigars ☐ Vaporizer or E-cig ☐ Snuff ☐ Chew Amount per day _______ Quit: _____ ☐ Interested in quitting
- Alcohol: ☐ Beer ☐ Wine ☐ Liquor Drinks per week: ____________
- Drugs: ☐ THC/Marijuana ☐ Cocaine ☐ Crack ☐ Heroin ☐ Synthetics ☐ Meth ☐ IV/injected drugs ☐ Someone else's pills ☐ Other

Have you ever been in substance use or addiction treatment? (Alcoholics or Narcotics anonymous, treatment program) ☐ Yes ☐ No

Do you gamble? ☐ Yes ☐ No

Sexual activity

Are you now, or have you ever been sexually active?: ☐ Yes ☐ No

My partners have included (select all that apply): ☐ Men ☐ Women ☐ Transgender

Number of lifetime sexual partners: ______ Have you ever had a sexually transmitted infection? ☐ Yes ☐ No

Do you use anything to prevent sexually transmitted infections or pregnancy? ☐ Condoms ☐ Birth control (method: __________________)

Other

Do you exercise regularly? ☐ Yes ☐ No Activities: _______________ How long (minutes)? ____________ How often? _____________

Do you have an advanced directive: ☐ Yes ☐ No Living Will: ☐ Yes ☐ No

POLST (Physician Orders for Life Sustaining Therapy) : ☐ Yes ☐ No

The information on this Patient Health History Form is correct to the best of my knowledge.

Patient or Guardian Signature: _______________________________________ Date: __________________

Physician Signature: ____ Date: __________________ *Updated 10/25/2017*