Dignity Health Medical Group
Saint Francis/St. Mary's
A Service of Dignity Health Medical Foundation

(Confidential Health History)

Name _____ **Today's Date** _____

Age _____ **Date of Birth** _____ **Date of last physical examination** _____

What is your reason for today's visit? _____

ILLNESS: Please indicate if you now have or have ever had any of the following illnesses. Please note the year you had the problem or when it started.

ALLERGIES _____
ANEMIA _____
CHRONIC ANXIETY _____
ARTHRITIS _____
ASTHMA _____
BACK PROBLEMS _____
BLEEDING DISORDER _____
BRONCHITIS _____
CANCER (breast, colon) _____
CATARACTS _____
DEPRESSION _____
DIABETES _____
EMPHYSEMA _____
EPILEPSY/SEIZURE _____
GOUT _____
HEADACHE _____
HEART DISEASE _____
HEPATITIS _____
HIGH BLOOD PRESSURE _____
HIGH CHOLESTEROL _____
KIDNEY DISEASE _____
LIVER DISEASE _____
MIGRAINE _____
MULTIPLE SCLEROSIS _____
OBSTRUCTIVE SLEEP APNEA _____
PNEUMONIA _____
PROSTATE _____
PSYCHIATRIC _____
SINUS PROBLEMS _____
SKIN CANCER _____
STROKE _____
THYROID DISEASE _____
TUBERCULOSIS _____
ULCERS _____
VASCULAR DISEASE/CIRCULATION _____
_____
VENEREAL DISEASE (herpes, HIV, etc.)
_____
VISION PROBLEMS _____

Other significant illnesses not listed: _____

_____

List any abnormal test (blood, x-rays, etc.): _____

_____

SURGERIES/HOSPITALIZATIONS: Please indicate the year if you had any of the listed surgeries.

APPENDIX _____
BREAST BIOPSY _____
BREAST MASTECTOMY _____
C-SECTION _____
CARDIAC SURGERY _____
D & C _____
CATARACT SURGERY _____
COLON/RECTAL SURGERY _____
HERNIA SURGERY _____
KNEE SURGERY _____
SHOULDER SURGERY _____
GALLBLADDER _____
HYSTERECTOMY _____
KIDNEY/BLADDER _____
TONSILS _____
TUBAL LIGATION _____
TUBES IN EARS _____
VASECTOMY _____

Please list any other significant surgeries (back, knee, hip, shoulder, thyroid, etc.) _____

_____

MEDICATIONS YOU ARE TAKING: Please include doses and times taken each day. _____

_____

_____

ALLERGIES TO MEDICATIONS: Please also describe your allergic reaction. _____

_____

_____

Patient Name _____ **DOB** _____

Dignity Health Medical Group-Sequoia

IMMUNIZATIONS AND PREVENTION (Please check and list the date you last had, if any.)

Tetanus _____
Influenza vaccine _____
Pneumonia vaccine _____
Colon cancer test _____
Upper endoscopy _____
TB skin test _____
Hearing test _____
Eye exam _____
Cholesterol _____
Shingles vaccine _____
PAP smear _____
Mammogram _____
Bone density _____
PSA test _____

FAMILY HISTORY

	Alive	Dead	Age	Chronic Health Problems/Cause of Death
Father	☐	☐	_____	_____
Mother	☐	☐	_____	_____
Brothers (#)	☐	☐	_____	_____
Sisters (#)	☐	☐	_____	_____
B or S	☐	☐	_____	_____
B or S	☐	☐	_____	_____
Spouse	☐	☐	_____	_____
Children (#)	☐	☐	_____	_____

Please check all the health problems in your relatives, and note which relative is affected:

	Who?		Who?
Bleeding problems	_____	High Blood pressure	_____
Cancer, breast	_____	Kidney Disease	_____
Cancer, colon	_____	Liver Disease	_____
Cancer	_____	Mental Disease	_____
Diabetes	_____	Seizures	_____
Glaucoma	_____	Stroke	_____
Heart disease	_____	Thyroid Problems	_____
Other	_____	Other	_____

SOCIAL & PERSONAL HISTORY

Answering these confidential questions honestly will allow an accurate assessment of your health risks. If you are uncomfortable with any of the questions, you have the option of not answering it.

Current Occupation: _____

Education Completed: _____ Where Born: _____

Marital Status: _____ Single _____ Married (Year_____) _____ Widowed (Year_____) _____ Separated (Year_____) _____ Divorced (Year_____)

Married: _____ times: 1st____ yrs, ____ children 2Nd___ yrs, ____ children 3rd____ yrs, ____ children

I Live With: _____

Currently use tobacco ____ Cigarette ____ Cigar ____ Pipe ____ Chew Amount/day: ____ Years: ____

Former smoker ____ Amount/day: ____ Years: ____ Quit date: ____ 2nd hand smoke exposure ____

Consume Alcohol ____ Type: _____ Amount/day: _____ or/week: _____

Use recreational drugs ____ Type: _____ Frequency: _____

Have ever used needles to inject drugs _____

Patient Name_____ **DOB** _____

Dignity Health Medical Group-Sequoia

Consume caffeine beverage: ____ Amount/day_____

Exercise regularly ____ Type:_____ Frequency/week_____

Use sunscreen ____ Take calcium supplements ____ Wear my seatbelt ____

Have had blood transfusions ____ Year: ____ Have tattoos _____

Sexual History: Are you sexually active? ____ Yes ____ No ____ Not currently

My sexual partner(s) is/are ____ male ____ female was/were ____ male ____ female

History of sexually transmitted diseases? ____ Yes ____ No

Use contraception ____ Type: _____

REVIEW OF SYSTEMS

General **None apply**

____ Significant weight loss ____ Fatigue or loss of energy ____ Difficultly sleeping _____Loss of feeling or well being

Comments: _____

_____

Eyes **None Apply**

____ Blurred vision ____ Double vision ____ Spots in front of eyes ____ Eye pain/irritation

____ Need for corrective lens

Comments: _____

_____

Ear-Nose-Throat **None Apply**

____ Chronic Headaches ____ Hearing loss ____ Ringing in ears ____ Dizziness ____ Ear pressure

____ Chronic nasal congestion ____ Recurrent sinus infections ____ Nose bleeds ____ Constant runny nose

____ Bleeding gums ____ Sore throat ____ Toothaches ____ Sores in mouth ____ Breath odo ____ Hoarseness

Comments: _____

_____

Cardiovascular **None Apply**

____ Chest pain ____ Heart racing ____ Heart palpitations ____ Heart murmur

____ Decreased exercise tolerance ____ Difficulty breathing when lying down

____ Awakening because of short of breath ____ Leg Swelling

____ Pain in back of legs of buttocks with exercise, better with rest

____ Sensitivity of hand/feet to temperature

Comments: _____

_____

Respiratory **None Apply**

____ Shortness of breath ____ Cough ____ Chest Congestion ____ Wheezing ____ Noisy breathing

____ Choking ____ Coughing up blood ____ History of tuberculosis(TB) ____ History of pneumonia

Comments: _____

_____

Patient Name_____ **DOB** _____

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Breast **None Apply**

____ Breast lump ____ Breast pain ____ Nipple discharge ____ Skin changes

____ If Female, perform monthly self exams

Comments: _____

_____

Gastrointestinal **None Apply**

____ Stomach pains ____ Nausea ____ Vomiting ____ Diarrhea ____ Constipation
____ Difficulty swallowing ____ Frequent heartburn ____ Indigestion ____ Belching/burping
____ Sour taste in mouth ____ Bloating ____ History of yellow jaundice ____ History of hepatitis
____ History of ulcers ____ History of colon polyps ____ Rectal bleeding ____ Rectal pain or irritation
____ Swelling/ bumps or hemorrhoids ____ Black, tarry stools

Comments: _____

_____

Endocrine **None Apply**

Unexpected changes in: ____ Tolerance to heat ____ Tolerance to cold ____ Unusual thirst ____ Hair loss

Comments: _____

_____

Genitourinary (men) **None Apply**

____ Frequent urination (____often at night) ____ Frequent urge to urination ____ Pain on urination
____ Blood in urine ____ Trouble Starting urination ____ Interruption of urine stream ____ Dribbling
____ Loss of bladder control ____ Pain swelling of penis ____ Discharge of penis
____ Pain/swelling/lump in Scrotum ____ Pain/swelling in groin ____ Decline in sexual desire
____ Difficulty having erections ____ Difficulty maintaining erections/reaching climax

Comments: _____

_____

Genitourinary (Women) Last period _____ **None Apply**

____ Frequent urination ____ Frequent urge to urination ____ Pain on urination ____ Blood in urine
____ Frequent urinary infections ____ Frequent loss of urination ____ Hot flashes ____ Pressure in vagina
____ Vaginal irritation ____ Vaginal dryness ____ Virginal discharge ____ Vaginal pain
____ Painful intercourse ____ Decline in sexual desire ____ Difficulty in sexual response
____ Inability to orgasm ____ Bleeding between periods ____ Irregular periods
____ Change in periods (flow/frequency) ____ PMS or troublesome symptoms before/during period
____ Pelvic pain ____ Took infertility medication ____ Taking hormone replacement
____ Abnormal PAP smear ____ Have had sexually transmitted disease
Age periods began ____ Periods occur every ____ days with light/med/heavy flow
Number pregnancies ____ Number of deliveries ____ Number of miscarriages/abortions ____

Comments: _____

_____

Patient Name_____ **DOB** _____

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Lymphatic and Hematologic **None Apply**

____ Unusual lymph node swelling (neck, armpit, groin) ____ Painful lymph nodes

____ History of anemia or low blood count ____ Blood clots ____ Easy bruising ____ Unusual bleeding

Comments: _____

_____

Musculoskeletal **None Apply**

____ Limb or joint pains ____ Limb or joint deformity ____ Limb or joint swelling/stiffness/redness

____ Muscle weakness ____ Loss of muscle bulk ____ Muscle spasm or twitching ____ Muscle aching

____ Recurring back or neck pain ____ Back or neck injury

Comments: _____

_____

Neurologic and psychologic **None Apply**

____ Seizures ____ Stroke ____ Tremors ____ Unusual clumsiness ____ Limb weakness

____ Numbness/tingling ____ History of significant head injury ____ Altered consciousness or black outs

____ Dizziness ____ Frequent headaches ____ History of migraine ____ Previous diagnosis of dementia

____ Lapse in memory ____ Periods of disorientation/confusion ____ Difficulty concentrating

____ Troublesome depression ____ Worry about things ____ Mood swings ____ History of metal illness

____ Unusual stress ____ History of physical abuse ____ History of mental abuse or mental trauma

____ Thoughts of hurting self or others ____ Panic attacks ____ Anxiety

Comments: _____

_____

Skin **None Apply**

____ Rash ____ Itching ____ Unusual dryness ____ Changes in pigmentation

Comments: _____

_____

Allergy/Immunologic **None Apply**

____ Seasonal allergics ____ Sensitivity to specific items ____ Frequent or unusual infections ____ Fever

Comments: _____

_____