

(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 _____	EPILEPSY/SEIZURE _____	PROSTATE _____
ANEMIA _____	GOUT _____	PSYCHIATRIC _____
CHRONIC ANXIETY _____	HEADACHE _____	SINUS PROBLEMS _____
ARTHRITIS _____	HEART DISEASE _____	SKIN CANCER _____
ASTHMA _____	HEPATITIS _____	STROKE _____
BACK PROBLEMS _____	HIGH BLOOD PRESSURE _____	THYROID DISEASE _____
BLEEDING DISORDER _____	HIGH CHOLESTEROL _____	TUBERCULOSIS _____
BRONCHITIS _____	KIDNEY DISEASE _____	ULCERS _____
CANCER (breast, colon) _____	LIVER DISEASE _____	VASCULAR DISEASE/CIRCULATION _____
CATARACTS _____	MIGRAINE _____	_____
DEPRESSION _____	MULTIPLE SCLEROSIS _____	VENEREAL DISEASE (herpes, HIV, etc.) _____
DIABETES _____	OBSTRUCTIVE SLEEP APNEA _____	_____
EMPHYSEMA _____	PNEUMONIA _____	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 _____	CATARACT SURGERY _____	HYSTERECTOMY _____
BREAST BIOPSY _____	COLON/RECTAL SURGERY _____	KIDNEY/BLADDER _____
BREAST MASTECTOMY _____	HERNIA SURGERY _____	TONSILS _____
C-SECTION _____	KNEE SURGERY _____	TUBAL LIGATION _____
CARDIAC SURGERY _____	SHOULDER SURGERY _____	TUBES IN EARS _____
D & C _____	GALLBLADDER _____	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 _____	TB skin test _____	PAP smear _____
Influenza vaccine _____	Hearing test _____	Mammogram _____
Pneumonia vaccine _____	Eye exam _____	Bone density _____
Colon cancer test _____	Cholesterol _____	PSA test _____
Upper endoscopy _____	Shingles vaccine _____	

**FAMILY HISTORY**

	Alive	Dead	Age	Chronic Health Problems/Cause of Death
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brothers (# )	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sisters (# )	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
B or S	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
B or S	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Children (# )	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

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: 1<sup>st</sup> \_\_\_\_\_ yrs, \_\_\_\_\_ children    2<sup>nd</sup> \_\_\_\_\_ yrs, \_\_\_\_\_ children    3<sup>rd</sup> \_\_\_\_\_ yrs, \_\_\_\_\_ children

I Live With: \_\_\_\_\_

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

Former smoker \_\_\_\_\_ Amount/day: \_\_\_\_\_ Years: \_\_\_\_\_ Quit date: \_\_\_\_\_ 2<sup>nd</sup> 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 \_\_\_ Difficulty 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 odor \_\_\_ 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 or 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 \_\_\_\_\_

Dignity Health Medical Group-Sequoia

**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 \_\_\_ Vaginal 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 \_\_\_\_\_

Dignity Health Medical Group-Sequoia

**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 mental 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: \_\_\_\_\_