BrownClinic P.L.L.P.
Personal Care From The People You Know And Trust.

Health History Profile

Name First _____ Middle _____ Last _____

Today's Date _____ Date of Birth _____

Address _____

_____

Telephone Number home _____

mobile _____

work _____

FILLING OUT THIS FORM

Answering these questions will help your doctor understand your health and how best to treat you.

GENERAL HEALTH

1. Why did you make this appointment? (Check all that apply.)

- ☐ Regular checkup
- ☐ First appointment to start care with a new doctor
- ☐ Switching doctors (from whom: _____
- ☐ Have a specific health problem-please explain _____

_____

2. In general, what do you consider to be your main health problem(s)? (Check all that apply.)

- ☐ Heart problems
- ☐ Stomach problems
- ☐ Ear, nose, or throat problems
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Depression/emotional problems
- ☐ Joint problems
- ☐ Other(s)-please explain _____

3. How would you describe your health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

4. Are you taking any prescription medicines?

☐ **YES.** Please list your medicines below *or* ☐ I brought my pill bottles or a list.

☐ **NO.** I don't take any prescription medicines. (If no, go to question no. 5.)

Name of medicine	Amount/ size of pill	How many pills or doses do you take at:			
Flurosemide EXAMPLE	20 mg	2 MORNING	2 NOON	DINNER	BED
		MORNING	NOON	DINNER	BED
		MORNING	NOON	DINNER	BED
		MORNING	NOON	DINNER	BED
		MORNING	NOON	DINNER	BED
		MORNING	NOON	DINNER	BED
		MORNING	NOON	DINNER	BED

Please use the back of this form if you have more prescription medicines.

5. What over-the-counter medicines, do you take regularly?

☐ Pain reliever (for example: Tylenol, Advil, Motrin, Aleve, aspirin)

☐ Vitamins

☐ Antacid (for example: Tums, Prilosec)

☐ Herbal medicine (please list) _____

☐ Other (please list) _____

☐ None – I do not take any over-the-counter medicines regularly.

6. Have you ever had any allergic reaction (bad effects) to a medicine or a shot?

☐ **YES.** Please write the name of the medicine and the effect you had.

☐ **NO.** I am not allergic to any medicines.

Medicine I am allergic to	What happens when I take it
Atenolol EXAMPLE	I get a rash

7. Do you get an allergic reaction (bad effect) from any of the following? Check all that apply.

☐ Latex (rubber gloves)

☐ grass or pollen

☐ eggs

☐ shellfish

☐ other _____

☐ NO – I have no allergies that I am aware of.

8. Have you ever been a patient in a hospital overnight?

☐ **YES.** If yes, explain EACH reason and when.

☐ **NO.** I have never been a patient in a hospital.

Surgeries/hospitalization or inpatient treament and reason	Date

9. Have you ever had a colonoscopy (a test to look at your insides by sending a camera through your bottom)? ☐ No ☐ Yes

When_____?

10. Have you ever received a blood transfusion (when you are given extra blood)? ☐ No ☐ Yes

When_____?

FOR WOMEN ONLY

11. Have you had a DEXA/Bone density test? ☐ No ☐ Yes

Date of last one_____?

12. Have you had a PAP smear? ☐ No ☐ Yes

Date of last one_____?

13. Have you ever had a PAP smear that was NOT normal? ☐ No ☐ Yes

When_____?

14. Have you had a mammogram (breast x-ray)? ☐ No ☐ Yes

Date of last one_____?

SHOTS

15. When was your last Tetanus shot? Year _____ ☐ Never ☐ Don't know

16. When was your last *Pneumonia* shot? Year _____ ☐ Never ☐ Don't know

17. When was your last Flu shot? Year _____ ☐ Never ☐ Don't know

SOCIAL HISTORY

18. Circle the highest grade you finished in school?

1 2 3 4	5 6 7 8	9 10 11 12	GED	1 2 3	1 2 3 4 +
Grade School	**Middle School**	**High School**		**Vocational School**	**College**

19. What language do you prefer to speak? ☐ English ☐ Spanish ☐ Other

20. How well can you read? ☐ Very well ☐ Well ☐ Not well ☐ I cannot read

21. What do you do during the day?

☐ Work full-time Occupation_____

☐ Work part-time

☐ Attend school

☐ Take care of children at home

☐ Go out most days (shop, visit, appointments)

☐ Stay home most days

☐ Other_____

22. Have you ever smoked cigarettes, cigars, used snuff, or chewed tobacco?

☐ No (if no, go to question 23)

☐ Yes

a. When did you start? _____

b. How much per week? _____

c. Have you quit? ☐ No ☐ Yes, when _____

d. Do you want to quit? ☐ No ☐ Yes ☐ Already Quit _____

23. Do you drink alcohol?

☐ No (if no, go to question 24)

☐ Yes

a. Have you ever felt you ought to cut down on your drinking? ☐ No ☐ Yes

b. Have people ever annoyed you by criticizing your drinking? ☐ No ☐ Yes

c. Have you ever felt bad or guilty about your drinking? ☐ No ☐ Yes

d. Have you ever had a drink first thing in the morning? ☐ No ☐ Yes

24. Are you ☐ Single ☐ Married ☐ Partnered ☐ Divorced or Separated ☐ Widowed?

25. Who lives in your house? _____

_____

26. Do you have sex with ☐ men ☐ women ☐ both ☐ neither?

27. Do you have any beliefs or practices from your religion, culture, or otherwise that your doctor should know? For example:

☐ I am a Jehovah's Witness and do not accept blood/blood products.

☐ I do not use birth control because of personal or religious beliefs.

☐ I fast (go without food) for periods of time for personal or religious reasons.

☐ I am a vegetarian (do not eat meat.)

☐ I am a vegan (do not eat anything that comes from an animal.)

☐ Other special diets or eating habits. (Please describe.) _____

☐ I use traditional medicines or treatments, such as acupuncture or herbs.

☐ Other beliefs _____

☐ No, I have no beliefs or practices that need to be included in my care.

28. Check any of the following things you use to help you walk.

☐ Cane ☐ Walker ☐ Wheelchair

☐ Other _____

☐ I do not need any help walking

29. Check any of the following types of help at home you receive (paid help or family and friends).

☐ Help with cleaning/laundry.

☐ Help with shopping.

☐ Help with personal care (bathing, dressing).

☐ Help with taking my medications.

☐ I do not use any help at home.

30. In the past year, have you been emotionally or physically abused by your partner or someone important to you? ☐ No ☐ Yes

31. In the past year have you been hit, pushed, shoved, kicked or threatened by a partner or someone important to you? ☐ No ☐ Yes

EXERCISE

Describe what kind of exercise you do. Check all that apply.	How many days per week do you exercise?	For how long do you exercise each day?
☐ walking	☐ once per week	☐ less than 15 minutes
☐ biking	☐ twice per week	☐ 15 - 30 minutes
☐ swimming	☐ 3 times per week	☐ 30 - 45 minutes
☐ weight training	☐ 4 times per week	☐ 45 minutes - 1 hour
☐ yoga	☐ 5 times per week	☐ over 1 hour
☐ other	☐ 6 times per week	
☐ I do not exercise	☐ 7 times per week or more	

FAMILY HISTORY

What medical problems do people in your family have?

Family member	Medical problems
Mother	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ Other _____
Father	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ Other _____
Sisters	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ Other _____
Brothers	☐ Diabetes (sugar) ☐ High blood pressure ☐ Heart problems ☐ Cancer ☐ Other _____

HISTORY OF MEDICAL CONDITIONS

Have you ever had any of the following conditions? (check all that apply)

☐ Anemia (low blood iron)
☐ Asthma (wheezing)
☐ Diabetes (sugar)
☐ Heart trouble
☐ Hemorrhoids (piles)
☐ Cancer
☐ Hepatitis (yellow jaundice)
☐ Tuberculosis (TB)
☐ Liver trouble
☐ Pneumonia
☐ Rheumatic fever
☐ Ulcers
☐ Stroke
☐ High blood pressure
☐ Skin problems
☐ Depression (feeling down or blue)
☐ Epilepsy (fits, seizures)
☐ Anxiety (nerves, panic attacks)
☐ VD, STD (Syphilis, Gonorrhea, Chlamydia, HIV)
☐ Other _____

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REVIEW OF SYSTEMS

General	☐ Loss of appetite ☐ Weight gain ☐ Fatigue ☐ Weight loss ☐ Sweats ☐ Fever or chills ☐ Insomnia ☐ Mental fogginess
Eyes	☐ Eye discharge ☐ Blurred vision ☐ Glasses ☐ Vision loss ☐ Eye pain ☐ Double vision ☐ Contacts ☐ Eye itching/irritation
Ears, Nose, Throat	☐ Decreased hearing ☐ Hoarseness ☐ Ringing in ears ☐ Dental devices ☐ Pain swallowing ☐ Ear pain ☐ Nose bleeds ☐ Brush & floss daily
Cardiovascular	☐ Chest pain at rest ☐ Peripheral edema ☐ Chest pain with activity ☐ Palpitations
Respiratory	☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Palpitations
Gastrointestinal	☐ Abdominal pain ☐ Constipation ☐ Diarrhea ☐ Blood in vomit ☐ Reflux/Heartburn ☐ Vomiting ☐ Nausea ☐ Bloody or dark stool
Genitourinary	☐ Difficulty urination ☐ Painful urination ☐ Incontinence ☐ Blood in urine ☐ Frequent urination ☐ Change in urine color ☐ Increased night urination
Musculoskeletal	☐ Muscle twitching ☐ Muscle aches ☐ Back pain ☐ Joint swelling ☐ Muscle weakness ☐ Stress fractures ☐ Joint pain ☐ Broken bones
Skin	☐ Dry skin ☐ Acne ☐ Suspicious mole ☐ Itching ☐ Rash ☐ Unwanted hair growth
Neurological	☐ Dizziness ☐ Tremors ☐ Weakness ☐ Numbness
Psychiatric	☐ Depression ☐ Self harm behavior ☐ Anxiety ☐ Suicidal thoughts
Endocrine	☐ Cold intolerance ☐ Increased thirst ☐ Heat intolerance ☐ Weight change
Hematologic/ Lymphatic	☐ Abnormal bruising ☐ Enlarged lymph nodes ☐ Easy bleeding

Emotional Health	Do you get upset easily? ☐ No ☐ Yes Do frightening thoughts keep coming into your mind? ☐ No ☐ Yes Have you ever been hospitalized for nerves, thoughts or moods? ☐ No ☐ Yes During the past 2 weeks, have you often been bothered by having little interest or pleasure in doing things? ☐ No ☐ Yes During the past 2 weeks, have you often been bothered by feeling down, depressed, or hopeless? ☐ No ☐ Yes Do you have any other problems with your emotional health? ☐ No ☐ Yes
Men Only	☐ Urinary frequency at night ☐ Pain or burning with urination ☐ Blood in urine ☐ Discharge from penis ☐ Difficulty with erection or ejaculation ☐ Testicular pain or swelling
Women Only	Age at onset of menstruation _____ Date of last menstruation _____ Average period occurs every _____ days and lasts _____ days Heavy periods, irregularity, spotting, pain, or discharge ☐ Number of pregnancies _____Number of live births_____ Are you pregnant or breastfeeding? ☐ No ☐ Yes Have you had, D&C, hysterectomy, or cesarean? ☐ No ☐ Yes Any urinary tract, bladder, or kidney infections within the last year? ☐ No ☐ Yes Any blood in your urine? ☐ No ☐ Yes Any problems with control of urination? ☐ No ☐ Yes Any hot flashes or sweating at night? ☐ No ☐ Yes Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ☐ No ☐ Yes Experienced any recent breast tenderness, lumps, or nipple discharge? ☐ No ☐ Yes Do you perform monthly self-breast examinations? ☐ No ☐ Yes