Essential Health Access
HEALTH HISTORY

Name: ____ Sex: ☐Male ☐Female Date:_______________

Date of Birth_____/_____/________ Marital Status: ☐ Married ☐Single ☐Separated ☐Divorced ☐Widowed

Do you have any health concerns? If yes, please list:

____

____

____

PAST MEDICAL HISTORY: Check conditions that doctors have followed you for in the past:

☐ High blood pressure/hypertension	☐ High Cholesterol	☐ Liver Disease	☐ Diabetes ("sugar")
☐ Thyroid Problems	☐ Kidney Disease	☐ Heart Attack/ By-pass Surgery	
☐ Heart Failure	☐ Heart Murmur	☐ Mitral Valve Prolapsed	☐ Stroke
☐ Seizures/Epilepsy	☐ Stomach Problems	☐ Intestinal Problems	☐ Reflux Disease
☐ Glaucoma	☐ Psychiatric Illness	☐ Arthritis	☐ Abnormal PAP

☐ Cancer: Type & Location____
☐ Other:____

Have you ever had: Positive Tuberculosis Test ☐Yes ☐No
Rheumatic Fever ☐Yes ☐No
Blood Transfusion ☐Yes ☐No

List any hospitalizations or surgeries you have had (including C-section):

____

____

List any drug allergies:

____

Are you allergic to latex? ☐Yes ☐No

List all current medications (including vitamins, herbal, and health food preparations):

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

PREVENTIVE CARE: When was your last:
Tetanus Booster___________ Flu Shot ___________ Pneumonia Vaccine __________ Hepatitis Vaccine____________

Flexible Sigmoidoscopy/Colonoscopy___________________________________ Bone Densitometry ________________

Female Only: How often do you examine your breasts?_______________ Do you see an OB/GYN doctor?___________ When was your last mammogram? ____________________________ When was your last PAP smear? _______________
Male Only: Do you do a testicular exam? _______________ Do you have any problems with erections? ______________ When was your last : prostate blood test (PSA)____________ Prostate/rectal exam? _____________________________

PLEASE COMPLETE SECOND PAGE

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SOCIAL HABITS

Have you ever used tobacco produces? ☐Yes ☐ No	Do you drink alcohol? ☐Yes ☐No
What Kind?____________________________	How many drinks per week? __________________
How much?____________________________	Have you ever felt you need to cut down? ☐Yes ☐No
For how many years?_____________________	Have you ever felt guilty about your drinking? ☐Yes ☐No
Date quit?_____________________________	Do you use drugs? ☐ Yes ☐No What type? __________
	How often?___________________________________

How many glasses/cups of caffeine do you drink daily? ______________Do you have guns in your home?_____________

Do you exercise outside of your job? ☐Yes ☐No Do you wear seatbelts? ☐ Always ☐ usually ☐ sometimes ☐ never

What is you occupation? ______________________________Who do you live with? __________________________

How do you learn best? ☐Read it ☐ Tell me ☐ Show me How much education have you completed? __________

Are you sexually active? ☐Yes ☐No, If so … ☐ 1 partner ☐multiple partners ☐ with women ☐ with men

Are you a parent ☐Yes ☐No

FAMILY HISTORY: Has anyone in your family had any of the following? (Check appropriate Box)

	Mother	Father	Maternal Grandparent	Paternal Grandparent	Brothers/ Sisters	Other
High Blood Pressures/ Hypertension						
Heart Attack/ Heart Surgery						
Diabetes						
Stroke						
Cancer (Type/Location						
Osteoporosis						
Thyroid Problems						
Mental Illness						
Glaucoma						

Please check any of the following problems that apply to you: _____ no problems

General
☐fever
☐ sweats

Respiratory
☐ cough
☐ shortness of breath
☐ wheezing
☐ shortness of breath with exertion

Ear/Nose/Throat
☐ Ear pain
☐ Runny nose
☐ Sneezing
☐ Post nasal drip

Genitourinary
☐ urinary frequency
☐ burning with urination
☐ blood in urine
☐ problems urinating
☐ awaken at night to
☐ urinate
☐ problems with sex
☐ constipation
☐ exposure to sexually
☐ transmitted disease
☐ Mental Health
☐ insomnia
☐ guilt
☐ depression
☐ anxiety
☐ suicidal thoughts

Skin
☐ rash
☐ changing mole
☐ itching
☐ slow healing
☐ wounds

Cardio
☐ chest pain or
☐ pressure
☐ ankle swelling
☐ palpitations

Daily Living
☐ violence in your home
☐ changes in functional ability
☐ changes in eating habits
☐ changes in sleeping habits

Endocrine System
☐ Excessive urination
☐ excessive thirst
☐ fatigue
☐ heat intolerance
☐ cold intolerance

Neurologic System
☐ numbness
☐ tingling
☐ headaches
☐ weakness

Allergy
☐ seasonal symptoms
☐ sneezing
☐ itchy eyes
☐ runny nose
☐ nasal congestion
☐ post nasal drip

Hematologic System
☐ easy bruising
☐ easy bleeding
☐ hard to stop bleeding

Musculoskeletal
☐ joint swelling
☐ joint pains
☐ muscle pains

Eyes
☐ blurred vision
☐ changing vision

GI System
☐ nausea
☐ vomiting
☐ abdominal pain
☐ diarrhea
☐ blood in stool

Nutrition
☐ On a special diet
☐ weight gain or
☐ loss greater than 10 pounds