Health Information

1. **Reason for visit** (PICK FROM EITHER A or B)
   A. □ Questions □ TB skin test □ Physical □ Lab work □ Immunization
      □ Depo injection □ FLU Shot □ Drug Test □ STD Test
   {Skip to #7 if you pick from list above}

   B. **General illness**
      □ cold/flu symptoms □ eye problem □ urinary changes
      □ allergies □ ear problem □ vaginal/penile discharge
      □ congestion □ abdominal pain □ muscle pain/joint pain
      □ sore throat □ nausea/vomiting □ anxiety/depression
      □ breathing problems □ diarrhea □ other ____________

2. Please describe the problem in your own words: ______________________________________________________________________

3. When did the problem first begin? __________ How often does the problem occur? __________ How long do you symptoms last? __________

4. How bad are you feeling? Circle one.
   
<table>
<thead>
<tr>
<th>0</th>
<th>1-2</th>
<th>3-4</th>
<th>5-6</th>
<th>7-8</th>
<th>9-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>very happy, no pain</td>
<td>hurts just a little bit</td>
<td>hurts a little more</td>
<td>hurts a lot</td>
<td>hurts even more</td>
<td>hurts as much as possible</td>
</tr>
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</table>

5. List any other symptoms you may be experiencing with this problem. ______________________________________________________________________

6. What makes the problem better? __________ Worse? __________

7. Do you have any drug allergies? □ No □ Yes List drug and reaction ______________________________________________________________________

8. Do you have any food or other allergies? □ No □ Yes List and describe the reaction ______________________________________________________________________

9. **Current Medications**
   Name __________ Dosage __________ Reason Prescribed ______________________________________________________________________

10. Date of last normal menstrual period __________

11. Caffeine use: □ Never □ < 2/day □ > 2/day □ > 2/week □ > 2/month How long? __________ Type: □ Coffee □ Soda □ Energy drinks

12. Check any you use:
   □ Cigarettes Amount __________ How long? __________
   □ Smokeless Tobacco Amount __________ How long? __________
   □ Vaping Amount __________ How long? __________

13. **Alcohol Use** □ Never □ < 2/day □ > 2/day □ > 2/week □ > 2/month How long? __________ Type: □ Beer □ Liquor □ Both Consuming 4-5 drinks in 2 hours □ No □ Yes

14. **Illegal drugs** □ Never □ < 2/day □ > 2/day □ > 2/week □ > 2/month How long? __________ Type: __________

15. **Medical History** Circle any current medical problems **YOU** have. Record date or year of diagnosis.
   Anemia □ Asthma □ Bleeding disorder □ Cancer □ Cerebral Palsy □ Colitis □ Congenital Defect □ Cystic Fibrosis □ Diabetes □ Epilepsy □ Heart murmur □ Heart problems □ Hepatitis □ High blood pressure □ Irritable Bowel □ Kidney stone □ Medical disability □ Mental problems □ Migraine Headaches □ Physical limitations □ Rheumatic Fever □ Arthritis □ Scoliosis □ Thyroid problems □ Tuberculosis □ Positive TB skin test
   Other: ______________________________________________________________________

16. List any surgeries with dates: ______________________________________________________________________

17. List any recent hospitalizations, reason & date: ______________________________________________________________________

18. **Family History** Has anyone in your immediate family (parents, siblings, grandparents) had a history of any of the following? List family member affected.
   □ Thyroid problems □ Alzheimer’s/Dementia □ Anemia-Sickle cell □ Asthma/Respiratory □ Bleeding disorders □ Cancer □ Diabetes □ Tuberculosis □ Heart Disease □ High blood pressure □ Mental/Emotional problems □ Stroke

19. Is your Mother living? □ Yes □ No Is your Father living? □ Yes □ No

20. Over the last 2 weeks, how often have you been bothered by:
   a. Feeling nervous, anxious or on edge?
      □ Not at all □ Several Days □ More than ½ the Days □ Nearly Every Day
   b. Not being able to stop or control my worrying?
      □ Not at all □ Several Days □ More than ½ the Days □ Nearly Every Day

21. During the past month, have you been bothered by:
   a. Little interest or pleasure in doing things?
      □ Not at all □ Several Days □ More than ½ the Days □ Nearly Every Day
   b. Feeling down, depressed or hopeless?
      □ Not at all □ Several Days □ More than ½ the Days □ Nearly Every Day