Health Information  W# _____________

1. Reason for visit (PICK FROM EITHER A or B)
   A.) □ Questions □ TB skin test □ Physical □ Lab work □ Birth Control options
       □ Immunization □ Depo Injection □ FLU Shot
       (Skip to #8)
   B.) General medicine/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. Where is the problem located? ___________________________________________

3. Please describe the problem in your own words: ____________________________________

4. When did the problem first begin? ___________ How often does the problem occur? ___________ How long do the symptoms last? ___________

5. How bad are you feeling? Circle one.
   - 0 very happy, no pain
   - 1-2 hurts a little bit
   - 3-4 hurts a little more
   - 5-6 hurts a whole lot
   - 7-8 hurts as much as possible

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

7. What makes the problem better?__________ Worse? ___________

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

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

10. Current Medications
   Name | Dosage | Reason Prescribed
   __________________________

11. Date of last normal menstrual period ____________

12. Are you on a Physician prescribed diet? □ No □ Yes
    □ Type? ___________

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

14. Tobacco Use: □ Never □ Yes, complete information below:
    □ Cigarettes □ < 1/2 pk/day □ 1/2 pk/day
    □ 1 pk/day □ >1 pk/day □ How Long? ___________
    □ Other: □ smokeless tobacco □ vaping □ Amt ________ How long? ___________

15. 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

16. Illegal drugs: □ Never □ < 2/day □ 2/day □ > 2/week □ > 2/month
    How long? ___________ Type: ___________

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

18. List any surgeries with dates: __________________________________________

19. List any recent hospitalizations, reason & date: ___________________________

20. 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 problems □ Cancer
    □ Diabetes □ Tuberculosis
    □ Heart Disease □ High blood pressure
    □ Mental/emotional problems □ Stroke

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