**Health History**

*(Please complete this entire form to the best of your knowledge. The areas that have a* **\*** *are optional.)*

|  |  |
| --- | --- |
| Name: (Last) (First) (Middle) | |
| Name You Wish To Be Addressed By: | **Date of Birth** (MM/DD/YYYY)**:** |
| Sex Assigned at Birth:   |  |  | | --- | --- | | * Male | * Female | | **\* Sexual Orientation:** *(Who you are romantically, physically, and/or spiritually attracted to)*   |  |  |  | | --- | --- | --- | | * Men | * Asexual |  | | * Women | * Bi/Pan-Sexual |  | |
| \* Gender Identity: *(How you perceive your gender and how you label yourself)*   |  |  |  | | --- | --- | --- | | * Male | * Trans Man | * Gender Queer | | * Female | * Trans Woman | * Other \_\_\_\_\_\_\_\_ | | **\* Gender Pronoun:** *(Pronoun you choose to use for yourself)*   |  |  |  | | --- | --- | --- | | * He | * They |  | | * She | * Ze | * Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

**Social History**

|  |  |  |
| --- | --- | --- |
| **Tobacco Screening:** | | |
| Do you currently ☐ smoke cigarettes, and/or  cigars, and/or  use smokeless tobacco | Yes | No |
| If you do smoke cigarettes, how many per day? | # | |
| Do you want to quit? | Yes | No |
| **Alcohol / Substance Use:** | | |
| Are you currently in recovery for alcohol or substance use? | Yes | No |
| **Alcohol Screening** | | |
| How many alcoholic drinks do you have in a typical week? | # | |
| If you drink, have you felt the need to cut down? | Yes | No |
| MEN: How many times in the past year have you had 5 or more drinks in a day? | None | 1 or more |
| WOMEN: How many times in the past year have you had 4 or more drinks in a day? | None | 1 or more |
| **Substance / Drug Screening** | | |
| Do you use recreational drugs/substance such as Marijuana, Cocaine, or Adderall (not prescribed to you)? | Yes | No |
| How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons? | None | 1 or more |
| Do you ever feel bad or guilty about your drug use? | Yes | No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Health Questionnaire-2 / PHQ-2** | | | I decline screening | |
| **Over the past 2 weeks, how often have you been bothered by any of the following problems?** *(Please circle one number for each question.)* | **Not at All** | **Several Days** | **More Than**  **Half the Days** | **Nearly Every Day** |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Intimate Partner Violence Screening / IPV** | I currently do not have a partner | | | I decline screening | | | **How often does your partner…?**  *(Please circle one number for each question.)* | **Never** | **Rarely** | **Sometimes** | **Fairly Often** | **Frequently** | | Physically hurt you | 1 | 2 | 3 | 4 | 5 | | Insult or talk down to you | 1 | 2 | 3 | 4 | 5 | | Threaten you with harm | 1 | 2 | 3 | 4 | 5 | | Scream or curse at you | 1 | 2 | 3 | 4 | 5 | |

**Personal History**

|  |  |  |
| --- | --- | --- |
| **Current Prescribed Medicine** *(List all)* | **Dose** | **Reason** |
| No Current Medications |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Current Herbal/Vitamins or Non-Prescribed Medicines** *(List all)* | | **Dose** *(If known)* |
| None | |  |
|  | |  |
|  | |  |
| **Allergies** *(Include drug and non-drug allergies)* | | **Type of Reaction** *(e.g. hives, rash, difficulty breathing)* |
| None | |  |
|  | |  |
|  | |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Are you being treated or have you been treated for the following conditions?** *(Please circle yes or no)* | | | | | | | | |
| Allergies | Y | N | High Cholesterol | Y | N | Seizure Disorder | Y | N |
| Anemia | Y | N | High Blood Pressure | Y | N | Skin Problems | Y | N |
| Asthma | Y | N | HIV | Y | N | Stomach Problems *(Please specify below)* | | |
| Blood Clot | Y | N | Kidney/Bladder Problems | Y | N | * Irritable Bowel Syndrome | Y | N |
| Diabetes | Y | N | Liver Problems/Hepatitis | Y | N | * Heartburn *(Reflux)* | Y | N |
| Cancer | Y | N | Mental Health Condition *(Please specify below)* | | | Thyroid Disorder | Y | N |
| Ear Problems | Y | N | * ADD/ADHD | Y | N | Tuberculosis (TB) | Y | N |
| Eating Disorder *(e.g. Anorexia/Bulimia)* | Y | N | * Anxiety | Y | N | Other: *(Please list)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Eye Problems | Y | N | * Depression | Y | N | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Headaches/Migraines | Y | N | * Other *(List under other)* | Y | N | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Heart Disease/Murmur/Stroke | Y | N | Pap Testing - Abnormal | Y | N | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

|  |  |
| --- | --- |
| **Hospitalization, Procedure, or Surgical History**  *(Please write none if you have not had any hospitalizations, procedures, or surgeries in the past.)* | **Date** |
| No Past Hospitalization, Procedures, or Surgeries |  |
|  |  |
|  |  |
|  |  |

**Family History** *(Parents, Siblings, Grandparents)*

|  |  |  |  |
| --- | --- | --- | --- |
| **Are you adopted?** *(Please circle yes or no)* | Y | N | □ Biological Family History Unknown *(Skip next section, then sign & date.)* |

**Has a family member had any of the following conditions?** *(Please circle yes or no.* ***If yes, indicate the relation to you****.)*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Condition** | | | **Relation To You** | **Condition** | | | **Relation To You** |
| Asthma | Y | N |  | Mental Health Condition *(Please specify below)* | | | |
| Bleeding Disorder | Y | N |  | * ADD/ADHD | Y | N |  |
| Cancer *(List type(s) below)* | Y | N |  | * Anxiety | Y | N |  |
|  | | |  | * Depression | Y | N |  |
|  | | |  | * Other *(List under other)* | Y | N |  |
| Diabetes | Y | N |  | Seizure Disorder | Y | N |  |
| Heart Disease/Stroke | Y | N |  | Thyroid Disorder | Y | N |  |
| Hepatitis | Y | N |  | Tuberculosis (TB) | Y | N |  |
| High Blood Pressure | Y | N |  | Other: *(Please list)­* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| High Cholesterol | Y | N |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

**Signature: Date: \_**