Health Information W# _____

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)

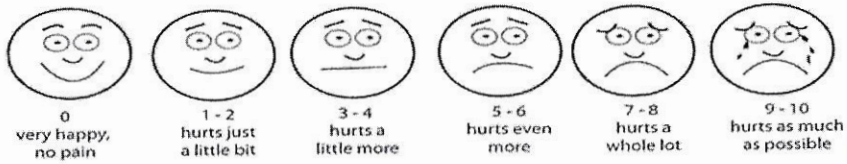
B.) General illness

□ cold/flu symptoms
□ allergies
□ congestion
□ sore throat
□breathing problems
□ eye problem
□ ear problem
□abdominal pain
□ nausea/vomiting
□ diarrhea
□urinary changes
□ vaginal/penile discharge
□ muscle pain/joint pain
□ anxiety/depression
□ 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 the symptoms last? _____
_____

4. How bad are you feeling? Circle one.



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, grand-parents) had a history of any of the following? List family member affected.

□ Thyroid problems _____
□ Anemia-Sickle cell _____
□ Bleeding problems _____
□ Diabetes _____
□ Heart Disease _____
□ Mental/emotional problems _____
□ Alzheimer's/Dementia _____
□ Asthma/Respiratory _____
□ Cancer _____
□ Tuberculosis _____
□ High blood pressure _____
□ 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 bother 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