

HEALTH HISTORY

Sierra College Health Services

Name: _____ SID #: _____ DOB: _____ Date: _____

List current medications (prescription, over-the-counter, herbal): **None** _____

 List medication or food allergies: None _____
 List prior surgeries: **None** _____
 List hospitalizations: **None** _____
 Are you at risk of domestic violence? Yes No

FAMILY HISTORY **Are you adopted?** Yes (do not fill this section) No

Has anyone in your family had problems with the following? M=Mother, F=father, S=sister, B=Brother, C=Children

Not No sure Yes			Who?	Not No sure Yes			Who?		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____

MEDICAL HISTORY **Have you had problems with:**

No	Yes	Now		No	Yes	Now	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding or Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Hepatitis/Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast Lumps/Tumor/Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mouth/Teeth
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Diseases (Gonorrhea, Chlamydia, Herpes, Syphilis, Genital Warts)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes/Vision (except glasses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

HEALTH HISTORY (continued)

Sierra College Health Services

WOMEN ONLY

No Yes Now

- Abnormal Pap Smear
 Pelvic Infection (PID)
 Pelvic Tumor/Fibroid
 Vaginal Infection
 Mammogram Normal Abnormal Date:_____

MENSTRUAL HISTORY

- Age period started _____
 Regular Irregular
 Light Moderate
 Painful Heavy
 Periods come every _____ days.
 Periods last _____ days
 Do you have bleeding between periods?
 Yes No Sometimes
 What was the date of first day of your recent period? _____
 Was it normal? Yes No
 Date of last Pap smear: _____
 Was it normal? Yes No

PREGNANCY HISTORY

- ____ Total # of pregnancies
 ____ Age at first pregnancy
 ____ Age at last pregnancy
Numbers of:
 ____ Live births
 ____ Abortions
 ____ Caesarians
 ____ Ectopic (tubal) pregnancies
 ____ Miscarriages
 ____ Premature births
 ____ Still birth
 Are you breast-feeding? Yes No

BIRTH CONTROL HISTORY

- Current Method:
 _____ None
 Previous Methods:

MEN ONLY

No Yes Now

- Epididymitis
 Prostatitis
 Urethritis

Have you had vaccinations for:

- | | | | |
|--------------------------------------|------------|--|------------|
| <input type="checkbox"/> Hepatitis A | When _____ | <input type="checkbox"/> MMR (Measles, Mumps, Rubella) | When _____ |
| <input type="checkbox"/> Hepatitis B | When _____ | <input type="checkbox"/> Polio | When _____ |
| <input type="checkbox"/> HPV | When _____ | <input type="checkbox"/> Tetanus and Diphtheria | When _____ |
| <input type="checkbox"/> Meningitis | When _____ | <input type="checkbox"/> Pertussis | When _____ |

SEXUAL HISTORY

- At what age did you begin having sexual intercourse? _____
 Total number of sexual partners in lifetime: ____ # of partners past one year: ____ Male Female Both
 How often do you use condoms? Always Never Sometimes

HABITS AND LIFE STYLE

- | | |
|--|---|
| Do you use street drugs? | <input type="checkbox"/> <input type="checkbox"/> What: _____ |
| Do you smoke cigarettes? | <input type="checkbox"/> <input type="checkbox"/> ____ Packs per day for ____ years |
| Do you use chewing tobacco? | <input type="checkbox"/> <input type="checkbox"/> How much _____ |
| Do you drink alcohol? | <input type="checkbox"/> <input type="checkbox"/> ____ Drinks per day or ____ Drinks per wk |
| Do you feel you have (had) problems with drugs or alcohol? | <input type="checkbox"/> <input type="checkbox"/> Explain: _____ |

 Patient Signature

 Date