Tuality Healthcare

Patient identification

Initial health history and assessment

Name: _____ **DOB:** ____/____/____ **Today's date:** ____/____/____
Last First M mo day yr mo day yr

Tel: _____ **Work:** _____ **Age:** _____

Primary care provider: _____

Why are you coming to the clinic today? _____

_____

Past medical and family history

For yourself, provide details and dates. For family members, please check (✓) if yes.

	Self	Mother	Father	Siblings	Children	Other
Stroke						
Heart disease						
Hypertension						
High cholesterol						
Asthma/emphysema						
Thyroid disease						
Diabetes						
Cancer - Type:						
Alcoholism						
Drug abuse						
Osteoporosis						
Arthritis						
Heartburn/ulcer						
Bowel problems						
Depression/Anxiety						
Hepatitis						
Eating disorders						

Other health issues: _____

_____

List any surgeries you have had:

Description **Date**

_____

_____

_____

_____

Gynecologic / obstetric history:

Age of first period: _____

Date of last menstrual period: _____/_____/_____

How many days between periods (average): _____

How long do periods last: _____

Bleeding between periods: ❒ Yes ❒ No

Bleeding after menopause: ❒ Yes ❒ No

Are periods too heavy/too painful: ❒ Yes ❒ No

Contraception: ❒ Yes ❒ No Type: _____

Are you sexual active: ❒ Yes ❒ No

With: ❒ Man ❒ Woman ❒ Both

Do you have sexual concerns: ❒ Yes ❒ No

Is intercourse painful: ❒ Yes ❒ No

New sexual partner in the last year: ❒ Yes ❒ No

Number of lifetime sexual partners:

❒ less than 5 ❒ more than 5

Number of pregnancies: _____

Vaginal deliveries: _____

C-sections: _____

Miscarriages: _____

Abortions: _____

Date of last pap: _____/_____/_____

History of abnormal pap smears: ❒ Yes ❒ No

History of sexually transmitted infections: ❒ Yes ❒ No

If so, type(s): _____

History of sexual or physical abuse: ❒ Yes ❒ No

Current sexual or physical abuse: ❒ Yes ❒ No

Do you perform self-breast exam: ❒ Yes ❒ No

Current medications (prescribed or over the counter) / supplements / herbs:

Medication / dose	**Medication / dose**	**Medication / dose**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List allergies to medication including reaction:

Medication / Reaction	**Medication / Reaction**
_____	_____
_____	_____

Social history and habits:

❒ Single ❒ Partnered ❒ Married ❒ Divorced / separated ❒ Widowed

Do you work outside the home? ❒ Yes ❒ No

What is your occupation? _____

Do you have children: ❒ Yes ❒ No Ages: _____

Do you exercise: ❒ Yes ❒ No Type/frequency: _____

Alcohol use: ❒ Yes ❒ No Amount per day/week: _____

Tobacco use: ❒ Yes ❒ No Past use: ❒ Yes ❒ No # of cigarettes per day: _____ Age began: _____ Age quit: _____

Drug use: ❒ Yes ❒ No Type: _____

Do you have any of the following symptoms currently:

- ❒ Abdominal or pelvic pain
- ❒ Constipation / diarrhea / blood in stool
- ❒ Heartburn / trouble swallowing
- ❒ Urine leakage
- ❒ Vaginal / vulvar itching, irritation, discharge
- ❒ Breast lumps / nipple discharge
- ❒ Chest pain
- ❒ Shortness of breath
- ❒ Visual / hearing problems
- ❒ Weight loss, fevers, chills, sweats
- ❒ Headaches - migraine or tension
- ❒ Numbness / tingling / weakness of extremities
- ❒ Joint / muscle pain
- ❒ Depression, anxiety, irritability, trouble sleeping
- ❒ Hot flashes / vaginal dryness
- ❒ Other concerns:_____

Screening / health maintenance:

		RESULT	
	Date of last exam / immunization	**Normal**	**Abnormal**
Pap smear			
Mammogram			
Bone Density Exam			
Cholesterol test			
Diabetes test			
Thyroid test			
Self breast exam			
Colon cancer screening			
Stool cards			
Flexible Sigmoidoscopy			
Colonoscopy			
Barium enema			
Immunizations			
Tetanus			
Hepatitis A			
Hepatitis B			
Human Papillomavirus (HPV)			
Measles / Mumps / Rubella			
Influenza			
Pneumonia			

Assessment completed by: _____ Date: _____

This page is for the doctor / provider to complete

Clarifying comments: _____

Assessment reviewed by: _____ **Date:** _____

Resident

_____ **Date:** _____

Attending Faculty

(02/20)