One Family medical group

HEALTH HISTORY

Legal name _____ Preferred name _____ Today's date _____

Please fill out both pages of this health history form. The information you provide will remain confidential.

HAVE YOU EVER HAD THE FOLLOWING? *(Circle below all that apply)*

Abnormal PAP	Drug or Alcohol Problem	Heart Disease	Kidney disease	Trauma
Arthritis	Emphysema	Hepatitis B	Liver disease	Tuberculosis
Asthma	Epilepsy	Hepatitis C	Osteoporosis	
Blood transfusion	Gastric Ulcer	HIV	Prostate problems	Other: _____
DVT	GERD	High cholesterol	Rheumatoid Arthritis	_____
Depression	Gout	High blood pressure	Stroke	_____
Diabetes	Heart Attack	Irritable bowel	Thyroid disease	_____

HAVE YOU EVER HAD CANCER? ☐ No ☐ Yes *(Which kind)* _____

WHEN WAS YOUR LAST...

Test	Never / NA	Approx .Year
Tetanus shot		
Pneumonia vaccine		
Colonoscopy		
Pap smear		
Bone mineral density		
Mammogram		
PSA		
Hepatitis		
STD		

SURGERY/PROCEDURE LIST

Surgery/Procedure	Year performed

MEDICATIONS *(Please list all medications you take regularly)*

Preferred Pharmacy _____

Medication	Dose	Frequency (how often)	Prescribing physician (or over-the-counter)

YOUR PERSONAL APPROACH TO HEALTH CARE...

Treatment / Medications	☐ Only when neccesary	☐ Evidence based and preventative	☐ Alternative
Testing & Screening	☐ Not interested in most	☐ Evidence based tests only	☐ Would like everything looked at
Patient Education	☐ Just what i need to get by	☐ Basic info on all of my conditions	☐ As much info as possible

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HEALTH HISTORY *(page 2)*

OHRP INFORMATION *(required by the State)*

Race ☐ American Indian or Alaskan Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian ☐ White ☐ Prefer not to answer

Ethnicity ☐ Hispanic or Latino ☐ Non-hispanic or Latino ☐ Unknown ☐ Prefer not to answer

MEDICATION ALLERGIES *(Please list all medication allergies and the reaction you have if you take them)*

Allergic to:	Reaction	Allergic to:	Reaction

FAMILY HEALTH HISTORY?

Are you adopted? ☐ Yes ☐ No

Has any blood relative had any of the following? *(Circle the condition and indicate the family member who has had it)*

Condition	Family member(s) *(example: maternal grandmother)*	Condition	Family member(s) *(example: maternal grandmother)*
Asthma		Heart disease	
Blood disorder		High cholesterol	
Cancer *(what kind?)*		Drug or Alcohol	
Mental health problems		Stroke	
Diabetes		Tuberculosis	
Kidney disease		Other:	

SOCIAL HISTORY

Highest level completed in school: _____ What is your occupation: _____

Do you smoke? ☐ Never ☐ Quit – When? _____ ☐ Yes – How much per day _____

Do you drink alcohol? ☐ Never ☐ Quit – When? _____ ☐ Yes – How much per day _____

Do you exercise? ☐ Sedentary ☐ 1 – 2x/month ☐ 1 – 2x/week ☐ 3 – 4x/week ☐ Nearly daily ☐ Daily

Have you completed a living will or advance directive? ☐ No ☐ Yes *(If so, please bring copy for your records)*

SEX ASSIGNED AT BIRTH

☐ Female ☐ Male ☐ Intersex

Menopause? ☐ N/A ☐ No ☐ Yes, since age ____

Date of last period _____ ☐ N/A

How many children have you had? _____

Full term births ? _____

BIRTH CONTROL METHOD

☐ Not active ☐ None B.C. _____

SEXUAL ORIENTATION

☐ Heterosexual ☐ Lesbian ☐ Bisexual ☐ Gay

☐ Monogomous ☐ Pansexual ☐ Polyamorous

☐ Other: _____

Please tell us a little about yourself and your biggest healthcare concerns:

_____

_____

_____

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