

## IMPERIAL CENTER FAMILY MEDICINE HEALTH HISTORY ASSESSMENT UPDATE

TODAY'S DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Allergies (to medications or other allergens): \_\_\_\_\_

### CURRENT MEDICATIONS (please include over-the-counter & herbal medications)

MEDICATION NAME	DOSE	HOW TAKEN/FREQUENCY

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Past Medical History (for example: diabetes, asthma, blood pressure, anxiety): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hospitalizations (including deliveries): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Surgeries (including "tubes tied", tonsillectomy, vasectomy) and approximate dates if known: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any new health problems or other issues you would like addressed today?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Screening Examinations, please list approximate date of your last:**

Mammogram \_\_\_\_\_  
 PAP smear \_\_\_\_\_  
 Bone Density \_\_\_\_\_

Tetanus Shot \_\_\_\_\_  
 EKG \_\_\_\_\_  
 Colonoscopy \_\_\_\_\_

Complete Physical \_\_\_\_\_  
 Prostate Test \_\_\_\_\_

**SOCIAL HISTORY (please check all that apply):**

Tobacco Use:  No  Yes  Stopped, when? \_\_\_\_\_  
If yes, check which:  Cigarettes \_\_\_\_ packs/day for \_\_\_\_ years  Pipe  Cigar  Chewing Tobacco

Alcohol Use:  No  Yes  
If yes, how many drinks per day/week/year? \_\_\_\_ drinks per \_\_\_\_  
Do you or others feel that you have a problem with alcohol? \_\_\_\_\_

Any Drug Use:  No  Yes  
If yes, check which:  presently  in past  
What drugs? \_\_\_\_\_

Living Situation:  Single  Married  Divorced  I live alone  I live with roommates  I live w/ significant other  
Any children?  No  Yes, If yes, please write gender/year of birth \_\_\_\_\_

Exercise?  Yes  No formal exercise  
Frequency? \_\_\_\_\_ Type: \_\_\_\_\_

Diet: Are you on a special diet, if yes, what type: \_\_\_\_\_  
Please list some things in your diet which are "good" \_\_\_\_\_  
Please list some things in your diet you know you need to change \_\_\_\_\_

Occupation: \_\_\_\_\_ or, if student: grade/school/course of study: \_\_\_\_\_

Nationality: \_\_\_\_\_ If international, date moved to US: \_\_\_\_\_

Religion: \_\_\_\_\_ Does faith play an important role in your life/health? \_\_\_\_\_

**FAMILY HISTORY (please list any diseases that your relatives have/had and approximate date of onset, ex. High blood pressure, stroke, psychological disease, cancer, heart attacks):**

Biological Father: age \_\_\_\_  Alive  Deceased  
Health Problems \_\_\_\_\_

Biological Mother: age \_\_\_\_  Alive  Deceased  
Health Problems \_\_\_\_\_

Siblings: (include ages) / Health Problems \_\_\_\_\_

Grandparents / Health Problems \_\_\_\_\_

**SEXUAL HISTORY (please check all that apply):**

Are you sexually active?  No  Yes  Male partner(s) only  Female partner(s) only  Both female/male partner(s)  
How many current partner(s)? \_\_\_\_ How many partner(s) in lifetime? \_\_\_\_  
Do you/partner use any birth control?  No  Yes  
If yes, what type? \_\_\_\_\_

Do you/partner use condoms?  No  Everytime  Sometimes

Concern about sexually transmitted diseases?  No  Yes  
If yes, what type? \_\_\_\_\_

**GYNECOLOGICAL HISTORY (women only):**

Regular monthly periods?  No  Yes Date of last period: \_\_\_\_\_

Number Pregnancies \_\_\_\_\_ Number of Children Born Alive \_\_\_\_\_ Number Miscarriages \_\_\_\_\_  
Number Stillborns \_\_\_\_\_ Number C/Sections \_\_\_\_\_ Other Outcomes \_\_\_\_\_  
Complications with pregnancies (explain if so): \_\_\_\_\_  
\_\_\_\_\_

**OTHER CONCERNS or CHANGES IN YOUR LIFE OF WHICH YOU WISH YOUR PROVIDER TO BE AWARE:**