Wahiawā Health

PATIENT HEALTH HISTORY

Name: _____

Date of Birth: _____Today's Date: _____

GENERAL MEDICAL HISTORY – please check conditions you have NOW or HAVE HAD in the past

☐ Head trauma ☐ Seizures ☐ Headaches (migraine, etc.) ☐ Developmental Delay ☐ Learning Problems ☐ Vision problem ☐ Hearing problem ☐ Gastrostomy Tube ☐ Sinus problem ☐ Snoring ☐ Sleep apnea ☐ Dental problems ☐ Ever passed out ☐ Heart problems ☐ Heart murmur ☐ High blood pressure ☐ High cholesterol	☐ Lung problems ☐ Asthma ☐ Tracheostomy ☐ GERD or heartburn ☐ Stomach problems ☐ Gastrostomy Tube ☐ Intestinal/colon problems ☐ Dysphagia/ Swallowing problems ☐ Liver problems ☐ Gallbladder problems ☐ Pancreatic problems ☐ Kidney problems ☐ Urinary tract problems ☐ Allergies ☐ Blood disorders ☐ Lymph node problems	☐ Cancer ☐ Diabetes ☐ Thyroid problems ☐ Sprain, strain or broken bones ☐ ADHD/ADD ☐ Musculoskeletal Problem ☐ Immune system problems ☐ Mental Illness: (depression, anxiety, Bipolar Disorder, etc.) Specify: _____ _____ ☐ Eating disorder ☐ Suicide attempts ☐ Physical abuse ☐ Mental / Verbal abuse ☐ Sexual abuse ☐ Experienced bullying	☐ Urinary problems ☐ Sexually transmitted disease ☐ Eczema ☐ Other Skin problems Specify:_____ ☐ Autism Spectrum Disorder ☐ Communicable Diseases ☐ Weight problem ☐ Alcoholism ☐ Tobacco use ☐ Drug abuse ☐ Other problems (list):

FAMILY HISTORY/List Relation of Family Member to Patient with History of Condition

☐ Asthma _____ ☐ Eczema _____ ☐ Allergies (specify)_____ _____ ☐ Migraines_____ ☐ Stroke_____ ☐ Heart problems/Murmur/blood disorder _____ ☐ Autism Spectrum Disorder_____ ☐ High blood pressure_____ _____ ☐ High cholesterol_____ ☐ Gout/arthritis/joint problems _____ ☐ AIDS/HIV_____ ☐ Sleep apnea_____ ☐ Cancer (specify):_____ _____	☐ Sudden Infant Death Syndrome_____ ☐ Developmental Delay/Learning Problems _____ ☐ Gynecological issues/PCOS (specify):_____ _____ ☐ Mental Illness: (depression, anxiety, Bipolar Disorder, etc.) (specify): _____ _____ ☐ Substance Abuse:_____ _____ ☐ Immune problems_____ ☐ Thyroid problems_____	☐ Diabetes_____ _____ ☐ Vision/Hearing problems _____ ☐ Liver problems_____ ☐ADHD/ADD_____ _____ ☐ Pancreatic/Gallbladder problems _____ ☐ Kidney/Urinary problems_____ _____ ☐Intestinal/Colon Problems _____ ☐GERD/heartburn/Stomach problems_____

PROCEDURES/HOSPITALIZATIONS/SURGERIES			
Month/Year	Surgery/Illness	Month/Year	Surgery/Illness

Do you take any medications, vitamins, herbs, or dietary supplements? ☐ yes ☐ no
If yes, what is it?_____
Do you have any allergies to medication(s)? ☐ yes ☐ no ***If yes, what is it?*** _____
Any allergies to food(s)? ☐ yes ☐ no ***If yes, what is it?*** _____
Do you have any environmental allergies? ☐ yes ☐ no ***If yes, what is it?*** _____

(FEMALES ONLY ages 11 and older)

Age menstrual periods began: _____
Number of days between your periods: _____
Last Menstrual Period? _____
How many days of flow: _____
Are your periods painful? ☐ yes ☐ no

Are you on Birth Control? ☐ yes ☐ no

Type of Birth Control:
☐ Pills ☐ IUD ☐ Implant ☐ Depo shot

SOCIAL HISTORY (ages 11 yrs and older)

Alcohol? ☐ yes ☐ no
If yes, drinks per week: _____

Smoking/Tobacco? ☐ yes ☐ no
If yes, Packs/day: _____ Years: _____

Smokeless Tobacco? ☐ yes ☐ no
Frequency? _____

E-Cigarette/Vape? ☐ yes ☐ no
Frequency? _____

Second-hand Smoke exposure? ☐ yes ☐ no

History of Illicit Drug Abuse? ☐ yes ☐ no
If yes, kind(s) of drug: _____
Frequency: _____

Daily Caffeine intake (coffee, tea, sodas)? ☐ yes ☐ no
_____

Exercise? ☐ yes ☐ no
Frequency: _____

Do you live alone or with others? _____

Do you feel safe at home? ☐ yes ☐ no
If no, please explain: _____

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PREVENTATIVE CARE HISTORY	
	DATE
When was your last Flu shot?	
Last Dental Exam?	
When was your Last Physical Exam?	
Do you have any other current specialist you see? If so, what is the specialty's name?	

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