

Anne Marie Moore, Women's Health Nurse Practitioner  
767 Willamette St, Suite 305, Eugene, OR 97401  
Phone (541) 393-2334 Fax (503) 296-5438

Name \_\_\_\_\_

Date \_\_\_\_\_

## Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. This form will not be put directly into your medical chart. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. Thank you!

Age \_\_\_\_\_ How would you rate your general health?  Excellent  Good  Fair  Poor

Main reason for today's visit: \_\_\_\_\_

Other concerns: \_\_\_\_\_

### REVIEW OF SYMPTOMS: Please check any current symptoms you have

#### Constitutional

- \_\_\_\_\_ Recent fevers/sweats
- \_\_\_\_\_ Unexplained weight loss/gain
- \_\_\_\_\_ Unexplained fatigue/weakness

#### Eyes

- \_\_\_\_\_ Change in vision

#### Ears/Nose/Throat/Mouth

- \_\_\_\_\_ Difficulty hearing/ringing in ears
- \_\_\_\_\_ Hay fever/allergies/congestion
- \_\_\_\_\_ Trouble swallowing

#### Cardiovascular

- \_\_\_\_\_ Chest pains/discomfort
- \_\_\_\_\_ Palpitations
- \_\_\_\_\_ Short of breath with exertion

#### Breast

- \_\_\_\_\_ Breast lump
- \_\_\_\_\_ Nipple discharge

#### Respiratory

- \_\_\_\_\_ Cough/wheeze
- \_\_\_\_\_ Coughing up blood

#### Gastrointestinal

- \_\_\_\_\_ Heartburn/reflux
- \_\_\_\_\_ Blood or change in bowel movement
- \_\_\_\_\_ Nausea/vomiting/diarrhea
- \_\_\_\_\_ Pain in abdomen

#### Genitourinary

- \_\_\_\_\_ Painful/bloody urination
- \_\_\_\_\_ Leaking urine
- \_\_\_\_\_ Nighttime urination
- \_\_\_\_\_ Discharge: penis or vagina
- \_\_\_\_\_ Unusual vaginal bleeding
- \_\_\_\_\_ Concern with sexual functions

#### Musculoskeletal

- \_\_\_\_\_ Muscle/joint pain
- \_\_\_\_\_ Recent back pain

#### Skin

- \_\_\_\_\_ Rash
- \_\_\_\_\_ New or change in mole

#### Neurological

- \_\_\_\_\_ Headaches
- \_\_\_\_\_ Memory loss
- \_\_\_\_\_ Fainting

#### Psychiatric

- \_\_\_\_\_ Anxiety/stress
- \_\_\_\_\_ Sleep problem

#### Blood/Lymphatic

- \_\_\_\_\_ Unexplained lumps
- \_\_\_\_\_ Easy bruising/bleeding

#### Endo

- \_\_\_\_\_ Cold/heat intolerance
- \_\_\_\_\_ Increase thirst/appetite

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless?  Yes  No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.

Medication	Dose (e.g., mg/pill)	How many times per day
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Allergies or reactions to medications: \_\_\_\_\_

### Date of your most recent IMMUNIZATIONS:

Hepatitis A \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Influenza (flu shot) \_\_\_\_\_ MMR \_\_\_\_\_ Pneumovax (pneumonia) \_\_\_\_\_  
Meningitis \_\_\_\_\_ Tetanus (Td) \_\_\_\_\_ Varicella (chicken pox) shot or illness \_\_\_\_\_ Tdap (tetanus & pertussis) \_\_\_\_\_

### HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol) \_\_\_\_\_ Date \_\_\_\_\_ Abnormal?  Yes  No

Sigmoidoscopy \_\_\_\_\_ or Colonoscopy \_\_\_\_\_ Date \_\_\_\_\_ Abnormal?  Yes  No

Women: Mammogram \_\_\_\_\_ Date \_\_\_\_\_ Abnormal?  Yes  No Pap Smear \_\_\_\_\_ Date \_\_\_\_\_ Abnormal?  Yes  No

Dexascan (osteoporosis) \_\_\_\_\_ Date \_\_\_\_\_ Abnormal?  Yes  No

**PERSONAL MEDICAL HISTORY:** Please indicate whether you have had any of the following medical problems (with dates).

\_\_\_\_\_ Heart disease: \_\_\_\_\_ High blood pressure \_\_\_\_\_ High cholesterol  
*specify type* \_\_\_\_\_ \_\_\_\_\_ Diabetes \_\_\_\_\_ Thyroid problem  
\_\_\_\_\_ Asthma/Lung disease \_\_\_\_\_ Other: (specify): \_\_\_\_\_ \_\_\_\_\_ Kidney disease  
\_\_\_\_\_ Cancer: (specify): \_\_\_\_\_

**SURGICAL HISTORY:** Please list all prior operations (with dates):

\_\_\_\_\_

**FAMILY HISTORY:** Please indicate the current status of your immediate family members:

Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism \_\_\_\_\_ High cholesterol \_\_\_\_\_  
Cancer, specify type \_\_\_\_\_ High blood pressure \_\_\_\_\_  
Heart disease \_\_\_\_\_ Stroke \_\_\_\_\_  
Depression/suicide \_\_\_\_\_ Bleeding or clotting disorder \_\_\_\_\_  
Genetic disorders \_\_\_\_\_ Asthma/COPD \_\_\_\_\_  
Diabetes \_\_\_\_\_ Other: \_\_\_\_\_

**SOCIAL HISTORY**

**Tobacco Use**

Cigarettes  Never  Quit Date \_\_\_\_\_  
 Current Smoker: packs/day \_\_\_\_\_ # of yrs \_\_\_\_\_  
Other Tobacco:  Pipe  Cigar  Snuff  Chew  
Are you interested in quitting?  No  Yes

**Alcohol Use**

Do you drink alcohol?  No  Yes # drinks/week \_\_\_\_\_  
Is your alcohol use a concern for you or others?  No  Yes

**Drug Use**

Do you use any recreational drugs?  No  Yes  
Have you ever used needles to inject drugs?  No  Yes

**Sexual Activity**

Sexually active:  Yes  No  Not currently  
Current sex partner(s) is/are:  male  female  
Birth control method: \_\_\_\_\_  None needed  
Have you ever had any sexually transmitted diseases (STDs)?  
 No  Yes  
Are you interested in being screened for sexually transmitted  
diseases?  No  Yes

**OTHER CONCERNS**

**Caffeine Intake:**  None  Coffee/tea/soda \_\_\_\_\_ cups/day  
**Weight:** Are you satisfied with your weight?  No  Yes  
**Diet:** How do you rate your diet?  Good  Fair  Poor  
Do you eat or drink four servings of dairy or soy daily or take  
calcium supplements?  No  Yes  
**Exercise:** Do you exercise regularly?  No  Yes  
What kind of exercise? \_\_\_\_\_  
How long (minutes) \_\_\_\_\_ How often? \_\_\_\_\_  
If you do not exercise, why? \_\_\_\_\_  
**Safety:** Do you use a bike helmet?  No  Yes  N/  
Do you use seatbelts consistently?  No  Yes  
Is violence at home a concern for you?  Yes  No  
Have you ever been abused?  Yes  No  
Do you have a gun in your home?  Yes  No  
**Have you completed a living will or  
or durable power of attorney for  
health care?**  Yes  No

**SOCIOECONOMICS** Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Years of education/highest degree: \_\_\_\_\_ Marital Status: Single Partner/Married Divorced Widowed Other: \_\_\_\_\_

Spouse/partner's name: \_\_\_\_\_ Number of children/ages: \_\_\_\_\_

Who lives at home with you? \_\_\_\_\_

**WOMEN'S HEALTH HISTORY** # pregnancies \_\_\_\_\_ # deliveries \_\_\_\_\_ # abortions \_\_\_\_\_ # miscarriages \_\_\_\_\_

Age at start of periods: \_\_\_\_\_ Age at end of periods: \_\_\_\_\_

» **CONFIDENTIAL**

*Do you have any other health concerns or questions that Anne Marie can discuss with you during your annual exam visit? If you will describe them here, I will be sure to prepare reference materials or referral information for your visit. Thanks for taking your time to return this information with your Health History Form.*

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