

Have you been **diagnosed** with any of the following health problems (**past or present**):

HEENT, Skin, Endocrine, Muscle/Bone/Joint, Neurological					
	Yes	No		Yes	No
Vision loss?	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma?	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts?	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal or environmental allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent sinusitis?	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss?	<input type="checkbox"/>	<input type="checkbox"/>
Frequent sore throats?	<input type="checkbox"/>	<input type="checkbox"/>	Dental problems?	<input type="checkbox"/>	<input type="checkbox"/>
Dry mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Unusual moles, lesions or sores?	<input type="checkbox"/>	<input type="checkbox"/>
Unusual rashes?	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems?	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain?	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
Back pain?	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain?	<input type="checkbox"/>	<input type="checkbox"/>
Unusual headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Migraines?	<input type="checkbox"/>	<input type="checkbox"/>
Seizures or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	Stroke?	<input type="checkbox"/>	<input type="checkbox"/>
Memory problems?	<input type="checkbox"/>	<input type="checkbox"/>	Balance problems?	<input type="checkbox"/>	<input type="checkbox"/>

Lungs, Heart, Digestive, Blood, Cancer					
	Yes	No		Yes	No
Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	Asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema?	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough (> 2 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack?	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
Irregular/fast heart beat?	<input type="checkbox"/>	<input type="checkbox"/>	Heart related chest pain?	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure?	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol / lipid problems?	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn or acid reflux?	<input type="checkbox"/>	<input type="checkbox"/>
Irritable bowel syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	Colitis?	<input type="checkbox"/>	<input type="checkbox"/>
Change in bowel habits, diarrhea or constipation?	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools?	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder problems?	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or liver problems?	<input type="checkbox"/>	<input type="checkbox"/>
Stomach ulcers?	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing?	<input type="checkbox"/>	<input type="checkbox"/>	Colon polyps?	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or clotting problems?	<input type="checkbox"/>	<input type="checkbox"/>	Anemia or low hemoglobin?	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots or deep vein thrombosis?	<input type="checkbox"/>	<input type="checkbox"/>	Vein inflammation or phlebitis?	<input type="checkbox"/>	<input type="checkbox"/>
History of a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	History of cancer?	<input type="checkbox"/>	<input type="checkbox"/>

Kidney, Genitourinary, Gynecological, Breast					
	Yes	No		Yes	No
Kidney stones?	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
Urination difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	Urine leakage?	<input type="checkbox"/>	<input type="checkbox"/>
Bladder or urinary infections?	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted infections?	<input type="checkbox"/>	<input type="checkbox"/>
Infertility?	<input type="checkbox"/>	<input type="checkbox"/>	Sexual concerns?	<input type="checkbox"/>	<input type="checkbox"/>
For men: Erection difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	For men: Prostate problems?	<input type="checkbox"/>	<input type="checkbox"/>
For women: Pain or problem periods?	<input type="checkbox"/>	<input type="checkbox"/>	For women: Frequent vaginal infections?	<input type="checkbox"/>	<input type="checkbox"/>
For women: Abnormal pap smears?	<input type="checkbox"/>	<input type="checkbox"/>	For women: Pelvic pain?	<input type="checkbox"/>	<input type="checkbox"/>
Breast problems?	<input type="checkbox"/>	<input type="checkbox"/>			

Genetic, Mental Health, Infections, Childhood Illnesses					
	Yes	No		Yes	No
Birth defects?	<input type="checkbox"/>	<input type="checkbox"/>	Genetic or hereditary disorders?	<input type="checkbox"/>	<input type="checkbox"/>
Depression?	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety?	<input type="checkbox"/>	<input type="checkbox"/>
Serious mental health problems?	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or drug problem?	<input type="checkbox"/>	<input type="checkbox"/>
History of physical, sexual or mental abuse?	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
Measles?	<input type="checkbox"/>	<input type="checkbox"/>	Mumps?	<input type="checkbox"/>	<input type="checkbox"/>
Rubella (German measles)?	<input type="checkbox"/>	<input type="checkbox"/>	Chickenpox?	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>	Polio?	<input type="checkbox"/>	<input type="checkbox"/>
Methicillin resistant staphylococcus (MRSA)?	<input type="checkbox"/>	<input type="checkbox"/>	Vancomycin resistant enterococcus (VRE)?	<input type="checkbox"/>	<input type="checkbox"/>

Surgical History

Staff: Enter in Surgical History

What kind of surgery have you had, if any? None

Procedure or Surgery	Date of procedure	Where was the surgery done?	Any complications?

Any problems with anesthesia? No Yes, please explain: _____

For Staff Only: Document history of malignant hyperthermia (995.86) in Medical History

Family History

Staff: Enter in History Activity or within the History Template of the Visit Navigator

<p>Use a check mark to indicate a family history of any of the following health problems. Also note the relationship of affected individual to you. Additional family members, put on back page.</p> <p><input type="checkbox"/> Adopted, no medical history for biological family members</p>			Alcohol/Drug use problem	Anesthesia Complications	Arthritis	Asthma	Blood or Bleeding Disorders	Cancer, Breast	Cancer, Colon	Cancer, Ovarian	Cancer, Other	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Inherited or Genetic Disease	Kidney Disease	Mental Health Problems	Obesity	Stroke	Thyroid Disease	Other
Parent	Mother	<input type="checkbox"/> Living																				
Parent	Father	<input type="checkbox"/> Living																				
Grandparent	Mom's Mother	<input type="checkbox"/> Living																				
Grandparent	Mom's Father	<input type="checkbox"/> Living																				
Grandparent	Dad's Mother	<input type="checkbox"/> Living																				
Grandparent	Dad's Father	<input type="checkbox"/> Living																				
Sibling	<input type="checkbox"/> Bro <input type="checkbox"/> Sis	<input type="checkbox"/> Living																				
Sibling	<input type="checkbox"/> Bro <input type="checkbox"/> Sis	<input type="checkbox"/> Living																				
Sibling	<input type="checkbox"/> Bro <input type="checkbox"/> Sis	<input type="checkbox"/> Living																				
Sibling	<input type="checkbox"/> Bro <input type="checkbox"/> Sis	<input type="checkbox"/> Living																				
Children	<input type="checkbox"/> Dau <input type="checkbox"/> Son	<input type="checkbox"/> Living																				
Children	<input type="checkbox"/> Dau <input type="checkbox"/> Son	<input type="checkbox"/> Living																				
Children	<input type="checkbox"/> Dau <input type="checkbox"/> Son	<input type="checkbox"/> Living																				

Do you have any hereditary diseases in your family not documented already above? No Yes, please describe:

Health Habits & Personal Safety Staff: Enter in History Activity or within the History Template of the Visit Navigator

Tobacco: Are you exposed to second hand smoke on a regular basis? No Yes, at home Yes, work
Do you use tobacco products? Yes Never Quit, date _____
If yes, what type(s)? Cigarettes Cigars Chew Snuff Pipe
If cigarettes, how many packs per day? <.25 0.5 1.0 1.5 2.0 _____
If using other types of tobacco, how much per day? _____
Are you interested in quitting? Yes Not interested

Alcohol: Alcohol use per week:
_____ Can(s) of beer _____ Drinks with 0.5 oz of alcohol _____ Glass(es) of wine _____ Shot(s)
 I do not drink alcohol Quit, date _____
Is your alcohol use a concern for you or others? No Yes

Drugs: Do you currently use recreational or street drugs? No Yes
If so, what kind? _____
How many times per week do you use? _____

Sexuality Are you sexually active? No Yes
Sexual partner(s) are Male Female
Birth Control & Infection Protection: None needed What kind? _____
Do you have any concerns about your sex life? No Yes

Diet: Do you feel you need assistance with healthy eating? No Yes
Do you follow a special diet? No Yes
Do you feel you have a weight problem? No Yes
What kind? _____

Exercise: Do you exercise less than 3-4 days per week? No Yes
What kind of exercise do you get? _____

Other Health Issues: Do you often get sleepy during the day? No Yes
Do you routinely not use your seatbelt? No Yes
Do you have unlocked weapons in your home? No Yes
Are you experiencing significant stress? No Yes

Social Documentation

Partner Information: Spouse or Partner's Name: _____
Occupation & Education: Your Occupation: _____ Your Years of education: _____

For Women – Obstetrical History

How many pregnancies have you had? _____ Miscarriages or pregnancy losses? _____ Premature deliveries? _____
What complications during pregnancy or childbirth, if any?

Preventive Health Screening

Have you had any of the following tests done **outside of CentraCare Health System**? If so, please list dates.
Lipids (cholesterol) _____ Colonoscopy _____ Bone density (DXA scan) _____
ECG (EKG) _____ For women: Mammogram _____ Pap smear _____
For men: PSA (prostate specific antigen) _____

Immunizations Staff: Enter into Immunization Activity

Most Recent Immunization Dates, if known: Hepatitis A _____ Pneumovax _____ Influenza _____
Hepatitis B _____ Varicella (Chickenpox) _____ Tetanus (TD) _____