Health Ministries Clinic
COMMUNITY HEALTH CENTER

HEALTH HISTORY (CONFIDENTIAL)

Name: _____ Today's Date: _____

Date of Birth: _____ Primary Care Physician: _____

Reason for Visit: _____

Medication: List all medications, prescription & non-prescription	Dose/Strength	# of pills/amts	Times/day

Medical History (Check (☑) conditions you have or have had in the past)

❑AIDS/HIV Positive	❑Rectal Bleeding	❑Hepatitis	❑Suicide Attempt
❑Alcoholism	❑Received blood transfusion	❑Pneumonia	❑Cataracts
❑Drug Addiction	❑Domestic Violence	❑Prostate Problems	❑Liver Disease
❑Anemia	❑Chicken Pox	❑Mental Condition: _____	❑Measles
❑Chest Pain	❑Diabetes	❑Rheumatic Fever	❑Migraine Headaches
❑Eating Disorder	❑Emphysema	❑Stroke	❑Hernia
❑Arthritis	❑Epilepsy	❑Cancer of _____	❑High Cholesterol
❑Asthma	❑Glaucoma	❑Thyroid Problems	❑Kidney Disease
❑Bleeding Disorder	❑High Blood Pressure	❑Tonsillitis	❑Multiple Sclerosis
❑Breast Lump	❑Stomach/Intestinal Problems	❑Tuberculosis (TB)	❑Other: _____
❑Chronic Bronchitis	❑Gout	❑Mumps	❑Other: _____
❑Pacemaker	❑Heart Disease	❑Depression	❑Other: _____

Allergies **ARE YOU ALLERGIC TO LATEX?** ❑No ❑Yes if yes, reaction _____

Allergy (Medication or Environmental)	Reaction

Gynecological History

Age when you started having periods: _____ Date of Last Menstrual Period: _____

Date of Last Pap Smear: _____ Result: _____

Date of Last Mammogram: _____ Result: _____

List any gynecological problems in past (i.e. endometriosis, breast lump, irregular periods, heavy bleeding, chronic pelvic pain) _____

Obstetrical History *(Please fill out for each pregnancy even if it was a miscarriage or abortion.)*

Type of Delivery (Miscarriage, Abortion, Vaginal Delivery, C-Section)	Date	Complications	Age

Surgical & Hospitalization History

List Type of Surgery or Reason for Hospitalization	Month/Year of Surgery

Family Medical History *(Please fill in health information about your family and check if your family has been diagnosed or treated for the following)*

Relation	Age	State of Health	Age of Death	Cancer	Diabetes	Hypertension	Heart Disease	Thyroid Disease	Lung Disease
Father									
Mother									
Daughter									
Son									
Siblings									

Social History

Tobacco Use: ❑ No ❑ Yes ❑ Former Type: _____ #Years: _____ # cigarettes/day: _____

How soon after waking up do you smoke: _____ Minutes Interested in quitting tobacco: ❑ No ❑ Yes ❑ Thinking about it

Passive Tobacco Exposure: ❑ No ❑ Yes

Sexually active? ❑ Yes ❑ No Any sexually transmitted diseases in the past? _____

Illicit Drug Use: ❑ No ❑ Yes ❑ Former Type: _____ Amt/day: _____ #Years: _____ Yr Quit: _____

Alcohol Use: ❑ Never ❑ Monthly ❑ Weekly ❑ Daily ❑ How many drinks are typical: _____

Caffeine Intake: Type – ❑ Coffee ❑ Tea ❑ Soda # of cups per day: _____

Exercise: ❑ 2-3x/week ❑ 3-4x/week ❑ Daily ❑ Never ❑ Occasional ❑ Rarely

Immunizations

Hepatitis B: ❑ I have received the entire Hepatitis B vaccination series
Flu Vaccine: ❑ I have received the Flu vaccine this year.
Pneumonia Vaccine: ❑ I have received a vaccine for Pneumonia.
Tdap ❑ I have received a vaccine for Tdap.

Sign: _____ Date: _____