Health Ministries Clinic
COMMUNITY HEALTH CENTER

HEALTH HISTORY (CONFIDENTIAL)

Name: _____ DOB: ____/____/_____
Last Name First Name Middle Name

Primary Care Provider: _____ Date: ____/____/_____

Reason for Visit: _____

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

☐ Anemia	☐ Liver Disease	☐ High Blood Pressure	☐ Eating Disorder
☐ Arthritis	☐ Chicken Pox	☐ Heart Disease	☐ Depression/Anxiety
☐ Asthma	☐ Kidney Disease	☐ Thyroid issues	☐ Drug Addiction
☐ Diabetes	☐ Chronic Bronchitis	☐ Stomach/Intestinal Problems	☐ Alcoholism
☐ Emphysema	☐ Migraine Headaches	☐ Dementia/memory loss	☐ AIDS/HIV Positive
☐ Epilepsy	☐ Rectal Bleeding	☐ Pacemaker	☐ Suicide Attempt
☐ Gout	☐ Prostate Problems	☐ Organ transplant	☐ Domestic Violence
☐ Hernia	☐ High Cholesterol	☐ Artificial Heart Valves	☐ Cancer of _____
☐ Chest Pain	☐ Multiple Sclerosis	☐ Received blood transfusion	☐ Mental Condition: _____
☐ Hepatitis	☐ Tuberculosis (TB)	☐ Bleeding Disorder	☐ Other: _____
☐ Stroke	☐ Breast Lump	☐ Pneumonia	☐ Other: _____
☐ Osteoporosis-If yes, list medication: _____			☐ Other: _____

Medication(s):

List all medications, prescription & non-prescription	Dosage	Frequency

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

Allergy (Medication or Environmental)	Reaction

Gynecological History

Age your menstrual cycle began: _____ Date of last menstrual cycle: ____/____/_____
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	Other
Father										
Mother										
Daughter										
Son										
Siblings										

Social History

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

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

Passive Tobacco Exposure ☐ Yes ☐ No

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

Alcohol Use ☐ No ☐ Daily ☐ Weekly ☐ Monthly ☐Socially How many drinks per occasion: _____

Sexually active ☐ Yes ☐ No - Any Sexually Transmitted Disease in the past? If yes, specify: _____

Caffeine Intake ☐ Tea ☐Soda ☐Coffee # of cups per day: _____

Exercise ☐ 2-3x/week ☐Daily ☐ Occasional ☐Never

Immunizations

Tdap ☐ I have received a vaccine for Tdap
Flu ☐ I have received the Flu vaccine this year
Covid ☐ I have received the Flu vaccine this year
Hep B ☐ I have received the Hepatitis B vaccination series
Shingles ☐ I have received the Shingles 2-series vaccination
Pneumonia ☐ I have received a vaccine for Pneumonia

Patient/Guardian (Print name) Relationship Parent/Guardian (Signature)