HEALTH HISTORY

RIVERSIDE FAMILY MEDICINE – BRENTWOOD MEDICAL CENTER
10510 Jefferson Ave, Suite A Newport News, VA 23601 757-594-3800

Date:_____

Name:_____Age:_____ Birth Date____/____/____
Last First MI Sex: Male Female
Highest Grade Completed_____
Place of Employment_____ How long?_____ Occupation_____
Single Married Separated Divorced Widowed

Others Who Live With You	Relationship	Age	Receive Care Here?
			yes no
			yes no
			yes no
			yes no
			yes no

Do you have any special spiritual, religious, or cultural needs? No Yes Explain _____

ALLERGIES: Any allergies or reactions to any medications, X-ray dyes, foods, environmental or other substances?
No Yes (please list)
1._____ 2._____ 3._____ 4._____

PAST MEDICAL HISTORY AND REVIEW OF SYMPTOMS:

Please circle if you have had problems with or are presently complaining of any of the following:

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest/Discomfort
6. Shortness of Breath
7. Swollen Ankles
8. Palpitations
9. Lightheadedness
10. Stroke
11. High Cholesterol
12. Fever, chills, sweats
13. Pneumonia
14. Persistent Cough
15. Tuberculosis (TB)
16. Asthma
17. Hayfever
18. Indigestion/heartburn
19. Abdominal Discomfort
20. Change in appetite
21. Constipation or diarrhea
22. Unexplained Weight Gain/Loss
23. Blood in Stool
24. Ulcers
25. Hemorrhoids
26. Gallbladder disease
27. Hepatitis/liver disease
28. Thyroid Disease
29. Seizures
30. Headaches
31. Incontinence
32. Kidney Diseases
33. Kidney Stones
34. Difficulty Urinating
35. Urine infections
36. Arthritis
37. Blood Disorder
38. Sickle cell
39. Blood clots
40. Anemia
41. Anxiety
42. Depression
43. Skin Diseases
44. Hearing difficulty
45. Gout
46. Low Back Problems
47. Glasses or contacts
48. Glaucoma/cataracts

Any problems not listed above: _____

Are you on a special diet? No Yes Type _____
Do you use any community resources? (i.e. Home Health, etc) No Yes Which? _____

FEMALE HEALTH HISTORY:
Age of start of periods:____years old
Frequency: _____Length of period:_____ days
Pregnancies: _____
Births: _____Miscarriages: _____
Method of Birth Control: _____

Prolonged or Abnormal Bleeding	**No**	**Yes**
Leakage of Urine:	**No**	**Yes**
Pelvic Pain:	**No**	**Yes**
Abnormal Discharge:	**No**	**Yes**
History of Abnormal Pap Smear	**No**	**Yes**
Sexually transmitted disease	**No**	**Yes**

MALE HEALTH HISTORY:

Testicular masses	**No**	**Yes**
Discharge from the penis	**No**	**Yes**
Sexually transmitted disease	**No**	**Yes**
Problems with erections	**No**	**Yes**
Difficulty Urinating	**No**	**Yes**

OPERATIONS: No Yes (please list)

Type of Operation	When

OTHER HOSPITALIZATIONS: No Yes (please list)

Reason	When

Vaccination History- Have you had?

Hepatitis B No Yes When? _____
Other? No Yes When? _____
When was your last?
Pap Smear _____ **Breast Exam** _____ **Stool Check for Blood** _____
Mammogram _____ **Cholesterol Check** _____ **Prostate Exam** _____

Tetanus Immunization No Yes When? _____
Flu Immunization No Yes When? _____
Pneumonia Immunization No Yes When? _____

FAMILY HISTORY:Has any member of your family (incl. parents, grandparents, and siblings) had the following?

Illness	Which Family Member?	Approximate Age when diagnosed
Cancer (describe type)		
High Blood Pressure		
Heart Disease		
Diabetes		
Stroke		
Mental Illness (anxiety, depression, etc.)		
Blood/clotting Disease		
Other:		

MEDICATIONS: (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose

Drug Name	Dose

PREVENTION:

Do you wear seat belts? No Yes
If no, why not?_____
Do you wear a bicycle or motorcycle helmet? No Yes Not applicable
Do you smoke or use tobacco products? No Yes If yes,how many packs/day? _____
Do you drink alcoholic beverages? No Yes If yes,how much/week? _____
Is there a gun in your home? No Yes
Do you use drugs? (marijuana, cocaine, crack, etc.) No Yes If yes, list_____
Any behaviors which would increase your risk of AIDS?
(IV drug use, unprotected intercourse, same sex relationship) No Yes If yes, list_____
Do you wish to be tested for AIDS? No Yes
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? No Yes
If Yes, please explain_____
Have you ever been afraid in your home? No Yes
Do you have a "living will"? No Yes
Are you an organ donor? No Yes

FOR PHYSICIAN USE ONLY

Initial ____Date ____ Initial ____Date ____ Initial ____Date ____ Initial ____Date ____ Initial ____Date ____