

Capital Family Physicians, P.A.

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 Raleigh, North Carolina 27607
 Phone: (919) 232-0020
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Date: _____ Physician: _____

HEALTH HISTORY ASSESSMENT

Name: _____ Birth Date: _____

Address: _____

Allergies (Medicine, Food, Latex, etc.)/Reactions: _____

Current Medications (Include medications taken for sleep and as a laxative)

MEDICATION	DOSE	FREQUENCY TAKEN	MEDICATION	DOSE	FREQUENCY TAKEN

Present/Previous Health Problems: (For family boxes, indicate for mother, father, sister, brother, children)

	Self	Family		Self	Family
Stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	Leg/Back/Neck Pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Seizures _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	Depression/Mental Illness _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis _____	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/Blood Clots _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid _____	<input type="checkbox"/>	<input type="checkbox"/>			

List Surgeries/Hospitalizations with Dates: _____

List Previous and Current Conditions Being Treated for (ex. high blood pressure, diabetes): _____

Please list the dates of your last:

Mammogram _____	Tetanus Shot _____	Cholesterol Test _____
Flexible Sigmoid _____	Flu Shot _____	TB Skin Test _____
Chest X-ray _____	Pneumonia Shot _____	MMR _____
EKG _____	Hepatitis B Shot _____	

Have you ever had a blood transfusion? No Yes When: _____

HEALTH HISTORY ASSESSMENT (Cont.)

Do you have an advanced directive? Living Will Health Care Power of Attorney No

Do you wear: Glasses Contacts Hearing Aid

Use of Tobacco: No Stopped When _____
 Cigarettes _____ Packs/day for # years _____ Pipe Cigar Chewing Tobacco Snuff

Use of Alcohol: No Occasionally Daily

Do you drink caffeine? Yes No

Where do you live? House Apartment Retirement Home Other _____

Do you live alone? Yes No With Family Other _____

Resources/support persons available to assist you: Spouse Other _____

Has there been a change in your marital status in the last year? No Yes _____

Has there been a death in your family in the last year? No Yes _____

Do you utilize: Cane Walker Wheelchair Crutches Artificial Limb

Do you need assistance with: Eating Walking Dressing Other _____

Have you had any problems with eating or drinking in recent weeks? No Yes

Problems with swallowing? No Yes Solids Liquids Pills

Unplanned weight gain/loss of 10 pounds or more in last 6 months or 5 pounds in one month? No Yes

Loss Gain _____ Pounds in _____ months

Do you have tooth or mouth problems that make it hard for you to eat? No Yes

Describe _____

Do you have: Dentures Bridges Caps Loose teeth

Do you eat fewer than 2 meals per day? No Yes

Are you on a special diet or supplement? No Yes

Do you exercise? No Yes Frequency _____ Type _____

Do you have trouble tolerating activity: No Yes Why? _____

Do you have any special requests due to your religious practices/culture/values? No Yes

Special Diet Blood Transfusion Other _____

Explain above _____

Religious Affiliation _____

Education: Last grade completed: _____

Present Occupation: _____

If retired, what was your previous employment? _____

How do you learn best? Reading TV/Video Demonstration Listening Doing

Do you have difficulty understanding and reading written materials? No Yes

Do you have a need for education about health or disease topics? No Yes Topic _____

Completed By: _____ Relationship to Patient: _____

SYSTEMS REVIEW

A. GENERAL

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Do you worry about your health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you usually feel tired? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you feel that stress is adversely affecting your health? | <input type="checkbox"/> | <input type="checkbox"/> |

COMMENTS

B. SKIN *Have you noticed:*

- | | | |
|---|--------------------------|--------------------------|
| 1. Skin rashes or itching | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Growths on the skin | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Sores that do not heal | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Change in the color or size of moles | <input type="checkbox"/> | <input type="checkbox"/> |

C. EYES *Have you noticed:*

- | | | |
|------------------------------------|--------------------------|--------------------------|
| 1. Blurred vision | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Double vision | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Draining or itching eyes | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Pain in your eyes | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Glaucoma check in the past year | <input type="checkbox"/> | <input type="checkbox"/> |

D. ENT *Have you had:*

- | | | |
|----------------------------------|--------------------------|--------------------------|
| 1. Difficulty hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Ringing in your ears | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Nasal stuffiness or drainage | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Frequent or severe nosebleeds | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Mouth sores that do not heal | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Recurrent sinus infections | <input type="checkbox"/> | <input type="checkbox"/> |

E. RESPIRATORY *Have you had:*

- | | | |
|---|--------------------------|--------------------------|
| 1. Difficulty breathing | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. To sleep on more than one pillow # _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Waking up short of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. A constant cough | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Coughing up blood | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Wheezing in your chest | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Exposure to tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Recurrent history of bronchitis | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Recurrent history of pneumonia | <input type="checkbox"/> | <input type="checkbox"/> |

F. CARDIOVASCULAR *Have you had:*

- | | | |
|--|--------------------------|--------------------------|
| 1. Pain/pressure in your chest, jaw, arm with exercise | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Palpitations of your heart at rest or during exercise | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. A previous heart murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Swelling in your ankles | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Cramps/pain in legs with walking | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Changes in the color of your fingers or toes | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. History of high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. History of abnormal EKG | <input type="checkbox"/> | <input type="checkbox"/> |

G. MUSCULOSKELETAL *Have you had:*

- | | | |
|--|--------------------------|--------------------------|
| 1. Pain in joints | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Swelling in joints | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Morning stiffness in joints | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Pain in joints in cold weather | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Pain in lower back which interferes with activities | <input type="checkbox"/> | <input type="checkbox"/> |

SYSTEMS REVIEW (Continued)

H. GASTROINTESTINAL <i>Have you had:</i>	YES	NO	COMMENTS
1. Any change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Any weight changes recently	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Abdominal or stomach pains	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Food intolerances (to fatty, greasy, spicy foods)	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Vomiting of blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Black or tarry stools	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Diarrhea in the last 3 months	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Constipation on regular basis	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Regular use of laxatives	<input type="checkbox"/>	<input type="checkbox"/>	_____

I. URINARY <i>Have you had:</i>			
1. Difficulty with urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Burning or pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Hesitation with urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Getting up at night to urinate more than one time	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Loss of urine with cough/sneeze	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Problems with sexual function	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. (Men) Prostate gland trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____

J. NERVOUS SYSTEM <i>Have you had:</i>			
1. Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Dizziness or light headedness	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Episodes of fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Seizures or convulsions	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Difficulty remembering recent events	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Episodes of crying	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. An urge to commit suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Frequent feelings of agitation or loss of control	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Tingling or numbness arms/legs	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Trouble speaking	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Difficulty with balance, coordination or weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____

K. GYN (WOMEN ONLY) <i>Have you had:</i>			
1. Regular monthly periods (Date last period: _____)	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Spotting/bleeding between your periods	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Heavy bleeding with your periods	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Pain or cramping with your periods	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Bloating/irritability before your period	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Use birth control (Form: _____)	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Have you passed menopause	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when? _____
10. Monthly breast self-exam	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how long? _____

Number Pregnancies _____ Number Children Born Alive _____ Number Miscarriages _____

Number Stillborns _____ Number C-sections _____

Complications with pregnancy(s) _____