Medical Health History

General Information

Name (first, middle, last)	Date of birth
Reason for your medical visit	**Today's date**
Previous medical providers	**Date of your last physical**

Gender identity

☐ Female
☐ Male
☐ Transgender female
☐ Transgender male
☐ Other/non-binary
☐ Choose not to disclose

Preferred pronouns

☐ She/her/hers
☐ He/him/his
☐ They/them/theirs
☐ Decline to answer
☐ Your name
☐ Other:

Questions

Are you currently pregnant or breastfeeding? (if applicable) .... ☐ Yes ☐ No

Have you been hospitalized recently, including for mental health reasons? .... ☐ Yes ☐ No

If yes, which hospital?........ ☐ Providence ☐ Alaska Regional ☐ Mat-Su ☐ API ☐ Other:

Medical Conditions

Have you ever had any of the following conditions?

☐ Anemia
☐ Anesthesia complications
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Blood disorder
☐ Blood transfusion
☐ Cancer
☐ Cataracts
☐ Congestive heart failure
☐ Chronic pain
☐ Clotting disorder
☐ COPD
☐ Depression
☐ Diabetes mellitus
☐ Emphysema
☐ Environmental allergies
☐ Fibromyalgia
☐ Gastrointestinal problems
☐ GERD/acid reflux
☐ Glaucoma
☐ Heart murmur
☐ HIV/AIDS
☐ High cholesterol
☐ High blood pressure
☐ Infertility
☐ Kidney problems
☐ Liver disease
☐ Meningitis
☐ Mental disorder
☐ Heart attack
☐ Nerve/muscle disease
☐ Osteoporosis
☐ Seizures
☐ Sickle cell anemia
☐ Sexually transmitted infections
☐ Stroke
☐ Substance use disorder
☐ Thyroid disease
☐ Trauma/violence
☐ Tuberculosis
☐ Urinary incontinence
☐ Urinary tract disorder

☐ Other:

Surgical History

Have you ever had any of the following surgeries?

- ☐ Appendix removal
- ☐ Brain surgery
- ☐ Heart surgery
- ☐ Gallbladder removal
- ☐ Colon surgery
- ☐ Colonoscopy
- ☐ Cosmetic surgery
- ☐ Ear surgery
- ☐ Upper endoscopy
- ☐ Eye surgery
- ☐ Hernia repair
- ☐ Joint replacement
- ☐ Orthopedic surgery
- ☐ Prostate surgery
- ☐ Small intestine surgery
- ☐ Spine surgery
- ☐ Tonsillectomy
- ☐ Heart valve replacement
- ☐ Vasectomy
- ☐ Cesarean section
- ☐ Other:

Health Screenings

Have you ever had any of the following health screenings?

Colon cancer screening............ ☐ Yes ☐ No **If yes:** ☐ Normal ☐ Abnormal

Date:

Screening type:

Lung cancer screening.............. ☐ Yes ☐ No **If yes:** ☐ Normal ☐ Abnormal

Date:

DEXA Scan (osteoporosis).......... ☐ Yes ☐ No **If yes:** ☐ Normal ☐ Abnormal

Date:

Mammogram (if applicable)...... ☐ Yes ☐ No **If yes:** ☐ Normal ☐ Abnormal

Date:

Pap smear (if applicable).......... ☐ Yes ☐ No **If yes:** ☐ Normal ☐ Abnormal

Date:

Family History

Please check all that apply.

	Cancer (type if known)	Death before age 50	Depression	Diabetes	Heart disease	High blood pressure	Other
Mother							
Father							
Sister							
Brother							
Daughter							
Son							
Other							

Social History

Sexual Activity

Are you sexually active?................................. ☐ Yes ☐ Not currently ☐ Never

If yes, are you using birth control?................... ☐ Yes. What kind? ☐ No

If yes, who is/are your partner or partners? ......
Check all that apply.

☐ Female
☐ Male
☐ Transgender female
☐ Transgender male
☐ Other/non-binary
☐ Choose not to disclose

Alcohol

Do you drink alcohol? .... ☐ Yes ☐ Not currently ☐ Never

If yes, how much do you drink each week?........

☐ Glasses of wine:
☐ Shots of liquor:
☐ Cans of beer:
☐ Other:

Substance Use

Do you use substances not prescribed to you by your medical provider?.................................. ☐ Yes ☐ Not currently ☐ Never

If yes, what kind?...

☐ Benzodiazepines
☐ Amphetamines
☐ Barbituates
☐ Cocaine
☐ Heroin
☐ Inhalants
☐ LSD
☐ Marijuana
☐ Methamphetamines
☐ Opioids
☐ Nitrous oxide
☐ PCP
☐ Other:

If yes, how many times do you use per week?... ☐ 0 to 1 ☐ 2 to 3 ☐ 4 to 5 ☐ 6 or more

Tobacco

Do you use tobacco?...................................... ☐ Yes ☐ Not currently ☐ Never

If yes, what kind?...

☐ Cigarettes
☐ Cigars
☐ Snuff
☐ Chew
☐ Other:

If yes, how often do you use tobacco? .... Number of packs per day:

If yes or not currently, when did you start using tobacco?.. Approximate start date:

If not currently, when did you stop using tobacco?.. Approximate quit date:

Vaping

Do you vape? .... ☐ Yes ☐ Not currently ☐ Never

If yes, how many times do you vape per day?.... ☐ 0 to 1 ☐ 2 to 3 ☐ 4 to 5 ☐ 6 or more

If yes, what do you vape?................................ ☐ Nicotine ☐ Marijuana ☐ Other:

If yes or not currently, when did you start using tobacco?... Approximate start date:

If not currently, when did you stop using tobacco?... Approximate quit date:

Treatment

If applicable, are you interested in treatment for substance misuse?.................................... ☐ Yes ☐ No

Current Medications

Medication	Dose	Start date

Allergies

Medication	Reaction	Severity