NORTHWEST COLORADO HEALTH

HEALTH HISTORY FORM

PATIENTS 12 AND OVER

Patient Name: ____ **Date of Birth:**__________________________

Existing Patients: Please check this box and initial if your health history has NOT changed in the last 12 months ☐ _____

Preferred Pharmacy: ______________________________ **City, State**: _________________________

Medication / Supplement	Dosage/Strength, Frequency

Allergies	Reaction

Are you current on your immunizations: ☐ YES ☐ NO ☐ UNSURE

General Health History – Check if you have had any of the following							
Arthritis or Gout		Bipolar		Stroke		Thyroid Problems	
Asthma/COPD/Emphysema		ADHD		Heart Disease		SLE (Lupus)	
Allergies		Eating Disorder		High Cholesterol		Multiple Sclerosis	
Bladder Problems/Kidney Disease		PTSD		High Blood Pressure		Skin Problem	
Blood clots in arms/legs/chest		Psychosis		Gallbladder Disease/Liver Disease		Tuberculosis	
Breast Disease		Suicide Attempt		Intestinal/Stomach Problems		Rheumatic Fever	
Cancer		Epilepsy/Seizure Disorder		Problems of the uterus or ovaries		Shingles	
Substance Abuse		Eye Problems		Prostate Problems		AIDS/HIV	
Depression/Anxiety		Headaches		Diabetes Type I or II		History of Chemotherapy or Radiation	
Have you ever had any serious illness not listed? If yes, please describe.							

Surgical History	
Date	**Type of Surgery / Procedure**

Medical / Psychiatric Hospitalization History	
Date	**Reason for Hospitalization**

Preventative Procedures	
All Patients	**Date / Result**
Have you ever had a Colonoscopy?	☐ YES ☐ NO Date:
When were you last tested for HIV? (The virus that causes AIDS)	
Women Only	**Date / Result**
When was your last pap smear?	
• Have you ever had any abnormal pap smears in the past?	☐ YES ☐ NO
What was the date of your last Mammogram?	
• Have you ever had any abnormal Mammograms in the past?	☐ YES ☐ NO

Family History

Family Member	Status	How Old?	Medical / Mental Health Illness
Father	Alive / Deceased		
Mother	Alive / Deceased		
Paternal Grandfather	Alive / Deceased		
Paternal Grandmother	Alive / Deceased		
Maternal Grandfather	Alive / Deceased		
Maternal Grandmother	Alive / Deceased		
Sister(s)	Alive / Deceased		
Brother(s)	Alive / Deceased		
Children	Alive / Deceased		
Other Relatives	Alive / Deceased		

Social History

Do you have access to food on an ongoing basis?	☐ YES ☐ NO
Do you have access to safe and secure housing?	☐ YES ☐ NO
Do you have access to transportation to get to your medical appointments?	☐ YES ☐ NO
If you have guns in your house, are they locked and unloaded?	☐ YES ☐ NO
Have you ever been forced to have sex?	☐ YES ☐ NO
Have you ever been hit, slapped, kicked, shaken or hurt by anyone?	☐ YES ☐ NO
Is there anyone that makes you feel unsafe now?	☐ YES ☐ NO
Do you / Did you ever experienced Domestic Violence?	☐ YES ☐ NO
Do you / Did you ever experienced Sexual Abuse?	☐ YES ☐ NO

Family Planning

Are you currently or have you previously been sexually active?	☐ YES ☐ NO
How many partners have you had in the past 60 days?	
• New partner in the last 60 days?	☐ YES ☐ NO
Have you ever had a STI?	☐ YES ☐ NO
• What type of STI have you had?	
• When were you diagnosed?	
• What type of treatment did you receive?	
Have you or your sexual partner(s) ever exchanged sex for drugs or money?	☐ YES ☐ NO
Have you or your sexual partner(s) ever used needles for drugs?	☐ YES ☐ NO
Have you or your sexual partner(s) ever had a blood transfusion, tissue/organ transplant, or artificial insemination?	☐ YES ☐ NO
• If yes, please explain and provide date:	
Are your partners: ☐Male ☐Female ☐Both	
Do you ever have: ☐Oral Sex (☐Give ☐ Receive) ☐Rectal Sex (☐Give ☐ Receive) ☐Vaginal Sex	
Are you planning on having children in the future?	☐ 0-1 years ☐ 2-4 years ☐ 4+ years ☐ Not currently planning
What method(s) of birth control are you using now?	
If you are under the age of 18	
Is there an adult with whom you feel comfortable talking about sexuality?	☐ YES ☐ NO
Have you discussed this visit with your parents?	☐ YES ☐ NO

MEN Only		
	Have you ever had any of the following?	☐ Abnormality of the penis ☐Discharge from the penis? ☐Current? ☐ Sores on the penis ☐Current? ☐ Sores or lumps on the scrotum? ☐Current?

Women Only		
	Age of first period:	
	Age when periods stopped?	
	Have you had sex without birth control since your last period?	☐ YES ☐ NO
	• If yes, when?	

Patient Signature: ______________________________ Date: ____________________

Provider Signature: ______________________________ Date: ____________________