**HEALTH HISTORY**

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Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last physical examination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your reason for this visit?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptoms**

Check (🗹) symptoms you currently have or have had in the past year.

**GENERAL**

🞏 Chills

🞏 Depression

🞏 Dizziness

🞏 Fainting

🞏 Fever

🞏 Forgetfulness

🞏 Headache

🞏 Loss of sleep

🞏 Loss of weight

🞏 Nervousness

🞏 Numbness

🞏 Sweats

**MUSCLE/JOINT/BONE**

Pain, weakness, or numbness

🞏 Arms 🞏 Hips

🞏 Back 🞏 Legs

🞏 Feet 🞏 Neck

🞏 Hands 🞏 Shoulders

**GENITO-URINARY**

🞏 Blood in Urine

🞏 Difficulty Urinating

🞏 Frequent Urination

🞏 Lack of Bladder Control

🞏 Painful Urination

**GASTROINTESTINAL**

🞏 Poor appetite

🞏 Bloating

🞏 Bowel changes

🞏 Blood in stool

🞏 Constipation

🞏 Diarrhea

🞏 Excessive hunger

🞏 Excessive thirst

🞏 Gas

🞏 Hemorrhoids

🞏 Indigestion

🞏 Nausea

🞏 Rectal bleeding

🞏 Stomach pain

🞏 Vomiting

🞏Vomiting Blood

**CARDIOVASCULAR**

🞏 Chest pain

🞏 High blood pressure

🞏 Irregular heartbeat

🞏 Low blood pressure

🞏 Poor circulation

🞏 Rapid heart beat

🞏 Swelling of ankles

🞏 Varicose veins

**EYE, EAR, NOSE, THROAT**

🞏 Bleeding gums

🞏 Blurred vision

🞏 Crossed eyes

🞏 Difficulty swallowing

🞏 Double vision

🞏 Earache

🞏 Ear discharge

🞏 Hay fever

🞏 Hoarseness

🞏 Loss of hearing

🞏 Nosebleeds

🞏 Persistent cough

🞏 Ringing in ears

🞏 Sinus problems

🞏 Vision – flashes

🞏 Vision – halos

**SKIN**

🞏 Bruise easily

🞏 Hives

🞏 Itching

🞏 Change in moles

🞏 Rash

🞏 Scars

🞏 Sore that won’t heal

**MEN ONLY**

🞏 Breast lump

🞏 Erectile dysfunction

🞏 Lump in testicles

🞏 Penis discharge

🞏 Sore on penis

🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN ONLY**

🞏 Abnormal pap smear

🞏 Bleeding between periods

🞏 Breast lump

🞏 Extreme menstrual pain

🞏 Hot flashes

🞏 Nipple discharge

🞏 Painful Intercourse

🞏 Vaginal discharge

🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last menstrual period:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last pap smear:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a mammogram?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children: \_\_\_\_

**Conditions**

Check (🗹) conditions you currently have or have been diagnosed with in the past.

🞏 AIDS/HIV positive

🞏 Alcoholism

🞏 Anemia

🞏 Arthritis

🞏 Asthma

🞏 Auto immune disorder

🞏 Bleeding disorders

🞏 Breast lump

🞏 Bronchitis

🞏 Cancer

If yes, what type:\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞏 Cataracts

🞏 Chemical dependency

🞏 Chronic kidney disease

🞏 COPD

🞏 Diabetes

🞏 Eating Disorder

🞏 Emphysema

🞏 Epilepsy

🞏 Glaucoma

🞏 Goiter

🞏 Gout

🞏 Heart Disease

🞏 Hepatitis

🞏 Hernia

🞏 Herpes

🞏 High Cholesterol

🞏 Liver disease

🞏 Migraine headaches

🞏 Mononucleosis

🞏 Multiple sclerosis

🞏 Neurological problems

🞏 Pacemaker

🞏 Pneumonia

🞏 Prostate problems

🞏 Psychiatric care

🞏 Rheumatic fever

🞏 Scarlet fever

🞏 Sexually transmitted infection

🞏 Stroke

🞏 Suicidal attempt

🞏 Thyroid problems

🞏 Tuberculosis

🞏 Ulcers

🞏 Vaginal infections

🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications Allergies**

List all medications and supplements you are currently taking. List any known Allergies

Drug Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Latex Allergy? Y or N

Prescription: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Over the Counter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Please let us know the state of health of your immediate family members

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Relation** | **Age** | **State of Health** | **If deceased, Age at Death** | **If deceased, Cause of Death** |
| Father |  |  |  |  |
| Mother |  |  |  |  |
| Brothers |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| Sisters |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Check (🗹) if your blood relatives have had any of the following:

|  |  |  |
| --- | --- | --- |
|  | **Condition/Disease** | **Relationship to you** |
|  | Arthritis |  |
|  | Asthma, Allergies, Hay Fever |  |
|  | Cancer |  |
|  | Chemical Dependency |  |
|  | Diabetes |  |
|  | Heart Disease, Stroke |  |
|  | High Blood Pressure |  |
|  | Kidney Disease |  |
|  | Mental Health Issues |  |
|  | Thyroid |  |

**Pregnancies**

**Occupational**

Check (🗹) if your work exposed you to:

|  |  |  |
| --- | --- | --- |
| **Year of Birth** | **Sex** | **Complications, if any** |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Stress |  | Hazardous Substances |
|  | Heavy Lifting |  | Other |
| Occupation: | | | |

**Health Habits**

Check (🗹) which you use and how much you use

|  |  |  |
| --- | --- | --- |
|  | Caffeine |  |
|  | Alcohol |  |
|  | Marijuana |  |
|  | Street Drugs |  |
|  | Seat Belt |  |
|  | Tobacco |  |

If yes to tobacco, do you use smokeless (oral), vape, or cigarettes?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hospitalizations/Surgeries/Procedures**

Please let us know about any in-office or overnight stays and procedures that you have had

|  |  |  |
| --- | --- | --- |
| **Year** | **Hospital/Doctor** | **Reason and Outcome** |
|  |  |  |
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Have you ever had a blood transfusion? Yes or No If yes, please give approximate date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Serious Illness/Injuries** | **Date** | **Outcome** |
|  |  |  |
|  |  |  |
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|  |  |  |

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my provider if I, or my minor child, ever have a change in health.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient, Parent, Guardian, or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by Date