GRAHAM HEALTH CENTER
HEALTH HISTORY

NAME: ______________________________ **ID#:** ______________

DATE: ______________

ALLERGIES TO MEDICATIONS?

MEDICAL HISTORY Please check all that apply	**PAST**	**NOW**
Anemia		
Attention Deficit/Hyperactivity		
Alcohol/Drug Problems		
Eating Disorder		
Arthritis		
Asthma/Chronic Bronchitis		
Cancer		
Cholesterol or lipid problems		
Depression/Anxiety		
Diabetes		
Digestive Problem		
Fractures/Broken Bones		
Gallbladder/Liver disease		
Heartburn		
Hay fever or sinus problems		
Headaches (chronic or migraine)		
Head Trauma		
Heart Problems		
High Blood Pressure		
HIV Infection		
Kidney or Bladder problems		
Liver problem (hepatitis)		
Mononucleosis		
Joint & Bone Problem		
Psychiatric Problems		
Pneumonia		
Rheumatic or Scarlett fever		
Sexually Transmitted Infection		
Seizures		
Sickle cell disorder/trait		
Speech/Hearing/Vision Problem		
Skin problems (eczema, psoriasis)		
Stroke/Blood Clot		
Thyroid/Endocrine Problem		
Blood Clot in Veins		
Tuberculosis		
Other		

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CURRENT MEDICATIONS (include vitamins, herbs, and over the counter)

Any previous surgery?

Family History		
	Current Age	Medical Problems
Father		
Mother		
Siblings		
Children		

FEMALES ONLY
When was your last menstrual period?
Are your menstrual periods regular? Yes or No
Do you have any menstrual problems? Yes or No
Number of pregnancies?
Number of live births?
Number of miscarriages?
Number of abortions?
When was your last pap smear?
When was your last mammogram?

REVIEWED BY: ______________________________ **DATE REVIEWED:** ______________

GRAHAM HEALTH CENTER
Health History

Name____

G#______________________________**DATE:**___________________

Do you smoke?	No	Yes	
Have you ever smoked? Quit date:	No	Yes	
Do you drink alcohol? Number of drinks a week:	No	Yes	
Is your use of alcohol a concern for you or for family/friends?	No	Yes	
Have you ever driven after drinking alcohol?	No	Yes	
Do you use recreation drugs?	No	Yes	
Are you currently sexually active?	No	Yes	
Current or past partners are:	Male	Female	Both
The last time you had sex was a condom used?	Yes	No	
Do you want to be tested for sexually transmitted infections?	No	Yes	
Are you satisfied with your current body weight?	Yes	No	
How would you rate your diet?	Good	Fair	Poor
Do you eat at least 5 servings of fruit/vegetables a day?	Yes	No	
Do you drink more than 2 caffeinated drinks a day?	No	Yes	
Do you exercise at least 2 ½ hours a week?	Yes	No	
Do you use a seat belt?	Yes	No	
Do you wear a helmet when biking/boarding/skiing?	Yes	No	
Do you use sunscreen?	Yes	No	
Do you use a tanning bed?	No	Yes	
Is violence at home a concern?	No	Yes	
Have you ever been abused (verbally/physically/sexually)?	No	Yes	
In the past two weeks have you:			
Felt little or no interest in things you typically enjoy?	No	Yes	
Felt depressed of hopeless?	No	Yes	
Do you have a problem with sleep (too little/too much)	Yes	No	
What is your stress level? (low) 1 2 3 4 5 6 7 8 9 10 (high)			

Date____________________________________ **Reviewed By:**___________________________