First Name _____ Last Name _____ Sex ____ Today's Date ____/____/____

Provider Name _____ DOB _____ Age _____ MRN _____

ROUTINE HEALTH ASSESSMENT – FAMILY/PERSONAL HISTORY

Names of other doctors who are currently caring for you and the condition they are treating

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Primary language ☐ English ☐ Spanish ☐ Other

Communication needs ☐ Interpreter ☐ Other

Any barriers to learning ☐ None ☐ Speech ☐ Cognitive ☐ Hearing ☐ Vision ☐ Inability to read/write

How do you learn best ☐ Verbal ☐ Reading ☐ Demonstration ☐ TV ☐ Pictures ☐ Groups

Do you have frequent contact or have children living in the same home ☐ No ☐ Yes If yes, please list below

1. _____ Age _____ Relationship _____

2. _____ Age _____ Relationship _____

3. _____ Age _____ Relationship _____

4. _____ Age _____ Relationship _____

5. _____ Age _____ Relationship _____

Religion **List any special religious or cultural needs** _____

RADIATION THERAPY TREATMENT

Start Date	Stop Date	Area of Body Treated	Hospital	Doctor

CHEMOTHERAPY TREATMENT

Start Date	Stop Date	Name of Chemo	Hospital	Doctor

PIH HEALTH

First Name _____ Last Name _____ Sex ____ Today's Date ____/____/____

Provider Name _____ DOB _____ Age _____ MRN _____

ALLERGIES ☐ **NKA (No Known Allergies)**

#1_____	#2_____	#3_____	#4_____
☐ Anaphylaxis	☐ Anaphylaxis	☐ Anaphylaxis	☐ Anaphylaxis
☐ Blood Disorders	☐ Blood Disorders	☐ Blood Disorders	☐ Blood Disorders
☐ Cardiac Arrest	☐ Cardiac Arrest	☐ Cardiac Arrest	☐ Cardiac Arrest
☐ Dyspnea (Shortness of Breath)	☐ Dyspnea (Shortness of Breath)	☐ Dyspnea (Shortness of Breath)	☐ Dyspnea (Shortness of Breath)
☐ Edema/Swelling	☐ Edema/Swelling	☐ Edema/Swelling	☐ Edema/Swelling
☐ Rash Hives Itch	☐ Rash Hives Itch	☐ Rash Hives Itch	☐ Rash Hives Itch

PAST MEDICAL HISTORY **Check if you've ever had** ☐ **No Active Problems**

☐ Anemia	☐ Gonorrhea	☐ Lung (Pulmonary) Disease	☐ Recurrent Colds (Upper Respiratory Infections)
☐ Asthma	☐ Hay Fever	☐ Measles	☐ Rheumatic Fever
☐ Cancer	☐ Heart Disease	☐ Meningitis	☐ Reported Prior Bone (Orthopedic)
☐ Chicken Pox (Varicella)	☐ HIV Infection	☐ Mumps	☐ Seizure Disorder
☐ Chlamydia Infection	☐ Hives	☐ Positive + Tuberculosis/ PPD Test (Tuberculin PPD Induration)	☐ Skin Disorder
☐ Classic Migraine (with Aura)	☐ Hypertension (High Blood Pressure)	☐ Pneumonia	☐ Tattoo
☐ Classic Migraine (w/out Aura)	☐ Joint Problems	☐ Polio	☐ Tuberculosis
☐ Depression	☐ Kidney (Renal) Disease	☐ Problems	☐ Type 1 Diabetes
☐ Eczema	☐ Kidney Stones (Nephrolithiasis)	☐ Recurrent Bacteria Infections	☐ Type 2 Diabetes
☐ Genital Herpes (Penis)	☐ Liver Disorder		☐ Whooping Cough (Pertussis)
☐ Genital Herpes (Vulva)			☐ Other _____

INJURIES

☐ Fracture (broken bones)
☐ Injuries/Accidents (major ones)
☐ Head Injury
☐ Joint Dislocations

HOSPITALIZATIONS

☐ Previous Hospitalizations?

If so, why? _____

PAST SURGICAL HISTORY **Check if you've ever had**

☐ Appendectomy
☐ Breast Surgery Mastectomy (breast removed)
☐ Blood Transfusion
☐ Breast Surgery Lumpectomy (Lump removed)
☐ Gallbladder Removed (Cholecystectomy)
☐ Hysterectomy
☐ Tonsillectomy
☐ Both Ovaries removed (Bilateral Oophorectomy)
☐ Single Ovary Removed (Unilateral Oophorectomy)
☐ Other _____

PREGNANCY/FEMALE HISTORY (if applicable)

Age at First Period ____ Years old (Menarche)
History of ____ Previous Pregnancies
☐ Menopause (history)
Previous Pregnancies Resulted in ____ Living Children
Previously Pregnant with ____ Normal Vaginal Deliveries
Previously Pregnant with ____ Cesarean Sections
Previously Pregnant with ____ Abortions (Elective)
Previously Pregnant with ____ Miscarriages
Previously Pregnant with ____ Tubal Pregnancies
Pregnancy Complications _____

First Name _____ Last Name _____ Sex ____ Today's Date ___/___/___

Provider Name _____ DOB _____ Age _____ MRN _____

SOCIAL HISTORY

MARITAL STATUS

☐ Single ☐ Single in One Relationship ☐ Currently Married ☐ Widowed ☐ Divorced

HIGHEST EDUCATION LEVEL COMPLETED

Grammar School (grade completed) _____

☐ GED ☐ Has High School Diploma ☐ Associate's Degree ☐ Bachelors Degree

☐ Masters Degree ☐ Doctorate ☐ Other _____

TOBACCO USE

☐ Never a Smoker ☐ Former Smoker

☐ Smoker

☐ Smoker status unknown ☐ Every Day Smoker

☐ Unknown if ever smoked

TYPE

☐ Number of cigars in a day _____

☐ Smoking a pipe - How often in a day _____

☐ Current smokeless tobacco user

☐ Number of cigarettes a day

NEED HELP? ☐ Considering to quit smoking

ALCOHOL USE

☐ Never Drank Alcohol

☐ Being a Social Drinker

☐ Moderate Drinker (2 Drinks/Day or Fewer)

☐ Heavy Alcohol Consumption

☐ Recovering Alcoholic

NEED HELP?

☐ Considering to quit drinking alcohol

DRUG USE

☐ Using Recreational Drugs ☐ Using Intravenous (IV) Drugs ☐ Drug Use Unable to Stop

NEED HELP? ☐ Considering to quit drug use

SEXUAL ACTIVITY SUMMARY

☐ Denies Sexual Activity ☐ Sexually Active With ____ Partners in the Last Yr

☐ Sexually Active ☐ Sexual Orientation Same Sex

OTHER

☐ Happy with Job ☐ Job Unsatisfying Occupation _____

☐ Exercise Regularly ☐ Moderate Exercising 3 Or More Times A Week

☐ Moderate Exercising Less Than 3 Times A Week ☐ Uses Safety Equipment – Seatbelts

☐ Uses Safety Equipment – Protective Head Gear ☐ Trouble sleeping

☐ Ever been hit or pushed by a partner?

☐ Material/Financial Abuse – Is anyone misusing your money? _____

FAMILY HEALTH STATUS

Relationship	Father	Mother	☐ Brother ☐ Sister	☐ Brother ☐ Sister	☐ Daughter ☐ Son	☐ Daughter ☐ Son	Other Relationship _____
DOB (Optional)	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Deceased Age							
Breast Cancer	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐

First Name _____ Last Name _____ Sex ____ Today's Date ____/____/____

Provider Name _____ DOB _____ Age _____ MRN _____

Relationship Con't	Father	Mother	☐ Brother ☐ Sister	☐ Brother ☐ Sister	☐ Daughter ☐ Son	☐ Daughter ☐ Son	Other Relationship _____
Asthma	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Mental Disorder	☐	☐	☐	☐	☐	☐	☐

MEDICATIONS

Name of Medication	Dose	How Often	Comments

PROBLEM LIST

Describe _____

_____

_____

_____

_____

_____

_____

First Name _____ Last Name _____ Sex ____ Today's Date ____/____/____

Provider Name _____ DOB _____ Age _____ MRN _____

IMMUNIZATIONS

☐ Yes ☐ No Tetanus/Pertussis (Tdap) Date _____
☐ Yes ☐ No Pneumovax Date _____
☐ Yes ☐ No Influenza (Flu) Date _____
☐ Yes ☐ No Zostavax (Shingles) Date _____

REVIEW OF SYSTEMS - Do you now or have you had within the past year any of the problems below?

Constitutional ☐ All Negative

☐ Y ☐ N Fever ☐ Y ☐ N Feeling Poorly ☐ Y ☐ N Recent Wt Gain (_____ Lbs)
☐ Y ☐ N Chills ☐ Y ☐ N Feeling Tired ☐ Y ☐ N Recent Wt Loss (_____ Lbs)

Eyes ☐ All Negative

☐ Y ☐ N Eye Pain ☐ Y ☐ N Eyesight Problems ☐ Y ☐ N Dry Eyes
☐ Y ☐ N Red Eyes ☐ Y ☐ N Discharge from Eyes ☐ Y ☐ N Eyes Itch

Ear/Nose/Throat ☐ All Negative

☐ Y ☐ N Earache ☐ Y ☐ N Nasal Discharge ☐ Y ☐ N Nosebleeds
☐ Y ☐ N Sore Throat ☐ Y ☐ N Loss of Hearing ☐ Y ☐ N Hoarseness
☐ Y ☐ N Ringing in the Ears

Cardiovascular ☐ All Negative

☐ Y ☐ N Heart Rate is Slow ☐ Y ☐ N Chest Pain ☐ Y ☐ N Heart Rate is Fast
☐ Y ☐ N Leg Pain With Exercise ☐ Y ☐ N Hoarseness ☐ Y ☐ N Palpitations

Respiratory ☐ All Negative

☐ Y ☐ N Shortness of Breath ☐ Y ☐ N Coughing Up Blood
☐ Y ☐ N Wheezing ☐ Y ☐ N Cough
☐ Y ☐ N Short of Breath on Exertion ☐ Y ☐ N Difficulty Breathing Lying Down
☐ Y ☐ N Awakening Short of Breath ☐ Y ☐ N Stop Breathing When Sleeping

Gastrointestinal ☐ All Negative

☐ Y ☐ N Abdominal Pain ☐ Y ☐ N Nausea ☐ Y ☐ N Vomiting
☐ Y ☐ N Constipation ☐ Y ☐ N Diarrhea ☐ Y ☐ N Blood Stools
☐ Y ☐ N Heartburn ☐ Y ☐ N Change in Bowel Habits

Genitourinary (Female) ☐ NA ☐ All Negative

Date of Last Menstrual Period _____ Cycle Length _____ days

☐ Y ☐ N Pain during Urination ☐ Y ☐ N Leaking of Urine ☐ Y ☐ N Pelvic Pain
☐ Y ☐ N Abnormal Vaginal Discharge ☐ Y ☐ N Blood in the Urine ☐ Y ☐ N Regular Periods
☐ Y ☐ N Abnormal Vaginal Bleeding ☐ Y ☐ N Urinary Frequency
☐ Y ☐ N Severe Menstrual Pain ☐ Y ☐ N Self Breast Exam
☐ Y ☐ N Used an Intrauterine Device (IUD)

Vaginal bleeding after intercourse ☐ Yes ☐ No
Painful menstruation ☐ Yes ☐ No
Irregular menstruation ☐ Yes ☐ No
Excessive menstruation ☐ Yes ☐ No

I was treated for female disorder; describe _____

Have you gone through Menopause? If yes, age of onset _____

Do you have hot flashes? ☐ None ☐ Mild ☐ Moderate ☐ Severe

First Name _____ Last Name _____ Sex ____ Today's Date ____/____/____

Provider Name _____ DOB _____ Age _____ MRN _____

Have you ever taken hormones? ☐ Yes ☐ No

If yes, indicate type _____

Duration _____ When stopped? _____

Have you ever taken birth control pills? ☐ Yes ☐ No

If yes, indicate type _____

Duration _____ When stopped? _____

Genitourinary (Male) ☐ NA ☐ All Negative

☐ Y	☐ N	Pain during Urination	☐ Y	☐ N	Leaking of Urine
☐ Y	☐ N	Difficulty Starting Urination	☐ Y	☐ N	Genital Lesion
☐ Y	☐ N	Blood in the Urine	☐ Y	☐ N	Frequent Urination at Night
☐ Y	☐ N	Testicular Pain	☐ Y	☐ N	Self Testicular Exam
☐ Y	☐ N	Urinary Frequency	☐ Y	☐ N	Erectile Dysfunction

Describe current erection function ☐ Normal ☐ Mild difficulty ☐ Moderate difficulty ☐ Severe difficulty

If you have difficulty, when did this begin? (month/year) _____

Musculoskeletal ☐ All Negative

☐ Y	☐ N	Joint Pains	☐ Y	☐ N	Joint Swelling	☐ Y	☐ N	Limb Pain
			☐ Y	☐ N	Muscle Aches	☐ Y	☐ N	Joint Stiffness
			☐ Y	☐ N	Limb Swelling	☐ Y	☐ N	Lower Back Pain

Integumentary ☐ All Negative

☐ Y	☐ N	Skin Rash	☐ Y	☐ N	Itching	☐ Y	☐ N	Breast Pain
☐ Y	☐ N	Skin Lesions	☐ Y	☐ N	Skin Wound	☐ Y	☐ N	Breast Lump

Neurological ☐ All Negative

☐ Y	☐ N	Headache	☐ Y	☐ N	Numbness	☐ Y	☐ N	Tingling
☐ Y	☐ N	Confusion	☐ Y	☐ N	Dizziness	☐ Y	☐ N	Limb Weakness
☐ Y	☐ N	Convulsions	☐ Y	☐ N	Fainting	☐ Y	☐ N	Difficulty Walking
☐ Y	☐ N	Loss of Consciousness						

Psychiatric ☐ All Negative

☐ Y	☐ N	Suicidal	☐ Y	☐ N	Anxiety	☐ Y	☐ N	Change in Personality
☐ Y	☐ N	Depression	☐ Y	☐ N	Sleep Disturbances	☐ Y	☐ N	Limb Weakness
☐ Y	☐ N	Loss of Pleasure from Usual Activities						

Endocrine ☐ All Negative

☐ Y	☐ N	Bulging Eyes	☐ Y	☐ N	Excessive Thirst	☐ Y	☐ N	Feelings of Weakness
☐ Y	☐ N	Hot Flashes	☐ Y	☐ N	Eat Excessively	☐ Y	☐ N	Muscle Weakness
☐ Y	☐ N	Excessive Urination	☐ Y	☐ N	Deepening of the Voice			

Heme/Lymph ☐ All Negative

☐ Y	☐ N	Swollen Glands	☐ Y	☐ N	Easy Bleeding	☐ Y	☐ N	Easy Bruising
☐ Y	☐ N	Swollen Glands in the Neck						

First Name _____ Last Name _____ Sex ____ Today's Date ____/____/____

Provider Name _____ DOB _____ Age _____ MRN _____

OTHER

Weight at 18 yrs _____ lbs

Maximum Weight _____ lbs

☐ Y ☐ N Do you have an Advanced Directive? If so, provide a copy.

☐ Y ☐ N Would you like information about Advanced Directive?

☐ Y ☐ N Do you wish to have an HIV test?

☐ Y ☐ N Is anyone hurting you or threatening you at home or elsewhere?

☐ Y ☐ N Is anyone misusing your money, food, clothing, housing or denying you medical care?

Bone Density Scan Year Last Done _____ Outcome _____

Colonoscopy Year Last Done _____ Outcome _____

Mammogram Year Last Done _____ Outcome _____

PAP Test Year Last Done _____ Outcome _____

ADDITIONAL COMMENTS

_____

_____

_____

_____

INFORMATION REVIEWED BY

Name _____ **Physician** _____ **Date/Time** _____

Name _____ **RN** _____ **Date/Time** _____

Name _____ **MA** _____ **Date/Time** _____

INFORMATION COMPLETED BY

Name _____ **Relationship** _____ **Date/Time** _____

INTERPRETER INFORMATION

Date _____ Time _____ Language _____

☐ Interpreter Name *(print)* _____ Department _____

☐ Interpretation Service/Interpreter Name _____ and Number _____

☐ Patient prefers family member or friend to interpret:

Family Member/Friend: Print Name _____

Relationship to Patient _____

PATIENT SIGNATURE

Date _____ Time _____

Signature _____

(Patient/Legal Representative)

If signed by someone other than the patient, indicate relationship _____

Print Name _____

(Legal Representative)

Witness Signature _____ Print Name _____