MOUNTAIN VALLEYS HEALTH CENTERS

HEALTH HISTORY

Name:_____DOB:_____Today's Date:_____

Please check and comment on all that apply. Any additional detail is helpful- year, right/left, etc.

Past or Current Medical History

□ Allergies_____
□ Anxiety_____
□ Arthritis_____
□ Arthritis, Rheumatoid_____
□ Asthma _____
□ Atrial Fibrillation_____
□ Anemia_____
□ Bleeding Disorders_____
□ Bladder Problems_____
□ Coronary Artery Disease_____
□ Chronic Obstructive Pulmonary Disease (COPD) _____
□ Cancer_____
□ Congestive Heart Failure (CHF)_____
□ Diabetes_____
□ Depression_____
□ Eyesight Problems_____
□ Gallbladder Disease_____
□ Gastric Ulcer_____
□ GERD_____
□ Gout_____
□ Hearing Loss_____
□ Hepatitis_____
□ HIV Infection_____
□ Hyperlipidemia (High Cholesterol)_____
□ Hypertension (High Blood Pressure)_____
□ Hypothyroidism_____
□ Insomnia_____
□ Low Back Pain_____
□ Migraine Headaches_____
□ Obesity_____
□ Osteoarthritis_____
□ Osteoporosis_____
□ Peripheral Vascular Disease_____
□ Psychiatric Disorders_____
□ Seizure Disorders_____
□ Sleep Apnea_____
□ Venereal Diseases_____
□ Number of Pregnancies_____
□ Number of Children_____

Other Disorders or Diagnosis that you have been given by any doctor_____

_____

Surgical History

Eye Ear Nose Throat

□ Cataract_____
□ Thyroid Surgery_____
□ Tonsillectomy_____
□ Adenoidectomy_____
□ Ear Surgery_____

Cardiovascular Surgery

□ Aortic Aneurysm_____
□ Angioplasty_____
□ CABG_____
□ Heart Valve_____
□ Cardiac Stent_____
□ Vascular Surgery_____

Breast Surgery

□ Mastectomy_____
□ Lumpectomy_____
□ Augmentation _____

Gastrointestinal Surgery

□ Abdominal Surgery_____
□ Appendectomy_____
□ Cholecystectomy (gallbladder removal)_____
□ Gastric Surgery_____
□ Hernia Repair_____
□ Ulcer Surgery_____
□ Laparoscopy_____
□ Pancreatic Surgery_____
□ Skin Surgery_____

Orthopedic Surgery

□ Joint Surgery_____
□ Carpal Tunnel_____
□ Back Surgery_____
□ Other_____

_____

GYN/GU Surgeries

□ Cesarean (C-section)_____
□ Hysterectomy_____
□ Tubal Ligation_____
□ Vasectomy_____
□ Bladder Surgery_____
□ Prostate Surgery_____
□ Kidney Surgery _____

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Health History Continued

ER or Urgent Care (Recent): _____

_____

Previous Hospitalizations: _____
(Please list details, such as, _____
reason, year, facility, etc) _____

Social History:
Alcohol: Type _____ How much/often?_____
Caffeine: Type_____How much/often?_____
Tobacco: Type _____ How much/often?_____
Street Drugs: Type _____How often?_____
Exercise: Type_____How much/often?_____
Special Dietary Needs:_____

Work History: Type of Work_____ Full Time, Part Time, Retired, Disabled
(Circle one of the above)

Family History:
Mother: Age:_____ *Living or Deceased*
If deceased, cause of death: _____
Any History of: Diabetes, Stroke, Heart Attack, High Blood Pressure, Cancer, Other:_____

Father: Age:_____ *Living or Deceased*
If deceased, cause of death: _____
Any History of: Diabetes, Stroke, Heart Attack, High Blood Pressure, Cancer, Other:_____

Brother(s): Age:_____ *Living or Deceased*
If deceased, cause of death: _____
Any History of: Diabetes, Stroke, Heart Attack, High Blood Pressure, Cancer, Other:_____

Sister(s): Age:_____ *Living or Deceased*
If deceased, cause of death: _____
Any History of: Diabetes, Stroke, Heart Attack, High Blood Pressure, Cancer, Other:_____

Other Pertinent Family History: _____
_____
_____

List Routine Care by Other Doctors/Specialists/Hospitals:
_____
_____

Recent Health Maintenance:

☐	Pap Smear:	Year _____	Results_____
☐	Mammogram	Year _____	Results_____
☐	Colonoscopy	Year _____	Results_____
☐	Cholesterol Screen	Year _____	Results_____
☐	Pneumonia Shot	Year _____	
☐	Tetanus: Tdap, Td	Year _____	