GRANGER MEDICAL CLINIC

Health History

Name: _____ Account #: _____
Age: _____ Today's Date: _____
DOB: _____

Active and Past Problems: Do you have or have you had any of the following problems?

- ☐ Abnormal pap
- ☐ Alcoholism
- ☐ Allergies / hay fever
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer:
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Eating disorder
- ☐ Ear infections
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fracture
- ☐ Gout
- ☐ Heart attack
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ High or low thyroid
- ☐ HIV / AIDS
- ☐ Incontinence (bladder leaks)
- ☐ Kidney disease
- ☐ Kidney stone
- ☐ Liver disease
- ☐ Lower back pain
- ☐ Other lung disease
- ☐ Pneumonia
- ☐ Reflux
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Sinus infections
- ☐ Stroke
- ☐ Tuberculosis or PPD Positive
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Other mental illness: _____
- ☐ Other: _____

Surgical History: Have you had any surgery?

- ☐ Adenoids
- ☐ Appendectomy
- ☐ Amputation
- ☐ D&C
- ☐ Fracture surgery
- ☐ Gall bladder
- ☐ Hernia repair
- ☐ Hysterectomy
- ☐ Ovary removal
- ☐ Parathyroid surgery
- ☐ Pituitary surgery
- ☐ Sinus
- ☐ Thyroid surgery
- ☐ Tubal ligation (tubes tied)
- ☐ Vasectomy
- ☐ Other _____

Obstetric History (women only):

How many pregnancies?_____
How many deliveries: Normal___ Premature___ Caesarian___ Miscarriage___ Abortion___

Do you take any medications?

Medication	Dose	Frequency	Medication	Dose	Frequency

Do you have any allergies or bad reactions to medications? What reaction?

Medication	Reaction	Medication	Reaction

Family History

Has anyone in your family had any of the following? (Please indicate who)

- ☐ Adrenal disease:
- ☐ Alcoholism:
- ☐ Arthritis:
- ☐ Asthma:
- ☐ Bi-polar disorder:
- ☐ Breast cancer:
- ☐ Colon cancer:
- ☐ Congestive heart disease:
- ☐ Diabetes:
- ☐ Depression:
- ☐ Emphysema:
- ☐ Heart attack:
- ☐ High blood pressure:
- ☐ High cholesterol:
- ☐ Kidney disease or stones:
- ☐ Liver disease:
- ☐ Migraines:
- ☐ Other heart disease:
- ☐ Other lung disease:
- ☐ Other mental disorder:
- ☐ Osteoporosis:
- ☐ Ovarian cancer:
- ☐ Pancreatic cancer:
- ☐ Pituitary disease:
- ☐ Prostate cancer:
- ☐ Rheumatoid arthritis:
- ☐ Stroke:
- ☐ Thyroid:
- ☐ Other cancer:
- ☐ Bone fractures:
- ☐ Elevated blood calcium:
- ☐ Parathyroid disease:

Other: _____

Social History

Marital history: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

How many children do you have? _____

With whom do you live? _____

What kind of work do you do? _____

Do you smoke? ☐ Yes ☐ No

If yes, how much? _____

Since what age? _____

If in past, how much? _____ For how long? _____

Do you drink alcohol? ☐ Never ☐ 0-2/day ☐ 2-4/day ☐ More(how much? _____)
☐ 1 or 2 occasionally ☐ Several on occasion ☐ Heavily on occasion

Do you drink caffeine? ☐ Never ☐ 0-2/day ☐ 2-4/day ☐ More(how much? _____)

Do you use drugs? ☐ Yes ☐ No ☐ In past only (if yes, how much? _____)

Do you exercise regularly? ☐ Yes ☐ No

Have you been seen by a dietitian in the past? ☐ Yes ☐ No

Are you now, or have you ever been, in an abusive relationship? ☐ Yes ☐ No

Health Maintenance

Do you see a dentist every 6 months? ☐ Yes ☐ No

When was your last flu shot? _____

If you are over 65 or have chronic illness, when was your last pneumonia shot?

If you are over 50, have you had a colonoscopy? ☐ Yes ☐ No When? _____

If there is a family history of colon cancer, have you had a colonoscopy? ☐ Yes ☐ No
When? _____

Women Only

If there is a family history of breast cancer, have you had a mammogram? ☐ Yes ☐ No
When? _____

Men Only

When was your last prostate exam? _____

When was your last PSA test (blood test for prostate cancer)? _____

Review of systems: Over the past two weeks, have you experienced any of the following?

- ☐ Abnormal Menstruation
- ☐ Anxiety
- ☐ Appetite loss
- ☐ Black or tar like stool
- ☐ Blood in stool
- ☐ Breast lump
- ☐ Change in urine habits
- ☐ Chest pain
- ☐ Chills
- ☐ Constipation
- ☐ Convulsions / seizures
- ☐ Cough
- ☐ Depression
- ☐ Diarrhea
- ☐ Difficulty sleeping
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Fever
- ☐ Feeling cold
- ☐ Hair loss
- ☐ Headaches
- ☐ Hearing loss
- ☐ Heart burn
- ☐ Joint pain Where?
- ☐ Joint swelling Where?
- ☐ Leg pain with exercise
- ☐ Loss of concentration
- ☐ Lower back pain
- ☐ Muscle aches
- ☐ Nausea
- ☐ Nail changes
- ☐ Night sweats
- ☐ Pain/burning with urination
- ☐ Pain during intercourse
- ☐ Palpitations or fast heart rate
- ☐ Rash
- ☐ Recent weight change: Loss Gain
- ☐ Sensory changes
- ☐ Stomach pains
- ☐ Swelling in legs and / or ankles
- ☐ Tingling / Numbness
- ☐ Tremors
- ☐ Vaginal discharge
- ☐ Vaginal itching or burning
- ☐ Vision problems
- ☐ Vomiting
- ☐ Yellow skin
- ☐ Other