UW Medicine
NORTHWEST PRIMARY CARE

Patient Label

Health History Form

DATE: _____

NAME: Last _____ **First** _____ **MI**_____**Gender:** _____ **Birthdate:** _____

PREFERRED PHARMACY: _____

REASON FOR VISIT: _____

Allergies:	**Medication or Substance**	**Reaction**
☐ No Allergies		

Current Medications:	**Label – Name**	**Dose**	**Frequency**
OR			
☐ See Attached List			

Social History

☐ Single ☐ Married (their name: _____) ☐ Domestic Partner (their name: _____) # Kids _____

Do you use tobacco products? ☐ Daily ☐ Some Days ☐ Quit ☐ Passive (around cigarette smoke) ☐ Never
Packs per Day _____ Years Smoked _____ Date Quit _____
Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Chew ☐ Snuff

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit Date Quit _____
Drinks per Day _____ Drinks per Week _____ Type: ☐ Beer ☐ Wine ☐ Liquor

Do you use recreational drugs? ☐ Never ☐ Yes – Use per Week _____ ☐ No ☐ Quit Date Quit _____
Have you ever used injected/IV drugs: ☐ Yes ☐ No
Types: ☐ Cocaine ☐ Marijuana ☐ Methamphetamines ☐ Stimulants ☐ Heroin
☐ Depressants ☐Hallucinogens (LSD, mushrooms) ☐ Opioids (vicodin, oxycodone)

Are you sexually active? ☐ Yes ☐ No Partners: ☐ Male ☐ Female ☐ Both Birth Control: _____

Are you working? ☐ Yes What do you do? _____ ☐ No ☐ Retired ☐ Disabled

Medical History — Please check box for those conditions you have now or have ever had

☐ No Past Medical History	☐ Congestive Heart Failure	☐ Gynecologic Problem	☐ Muscle or Joint Pain
☐ Allergies	☐ COPD/Emphysema	☐ Heart Murmur	☐ Heart Attack
☐ Anemia	☐ Heart Disease	☐ Hepatitis or Liver Problems	☐ Osteoporosis (Thin Bones)
☐ Anxiety	☐ Depression	☐ HIV/AIDS	☐ PPD
☐ Arthritis	☐ Diabetes Type 1	☐ Hypertension/High BP	☐ Seizures or Epilepsy
☐ Asthma	☐ Diabetes Type 2	☐ Insomnia / Sleep Problems	☐ Stroke
☐ Bleeding/Clotting Problems	☐ Gastric Ulcer / Stomach Ulcer	☐ Kidney Disease	☐ Substance / Drug Abuse
☐ Blood Transfusion	☐ GERD (Acid Reflux, Heart Burn)	☐ High Cholesterol	☐ Thyroid Disease
☐ Cancer	☐ Glaucoma	☐ Migraine	☐ Tuberculosis

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☐ Other (Please list): _____
_____

Surgical History — Please check box for any surgery you have had, indicate the year

☐ No Past Surgical History
☐ Appendix Removal (_____)
☐ Back Surgery (_____)
☐ Blood Transfusion (_____)
☐ Breast Surgery (_____)
☐ C-Section (_____)
☐ Heart Bypass Surgery (_____)
☐ Cancer Surgery (_____)
☐ Cataract Removal/IOL Implant (_____)
☐ Gall Bladder Surgery (_____)
☐ Colonoscopy (_____)
☐ Colposcopy (_____)
☐ Abdominal Surgery (_____)
☐ Hernia Repair (_____)
☐ Hysterectomy or Uterus Removal (_____)
☐ Joint Replacement (_____)
☐ Pacemaker/Defibrillator (_____)
☐ Splenectomy (_____)
☐ Thyroid Surgery (_____)
☐ Tonsillectomy (_____)
☐ Tubal Ligation (_____)
☐ Ear Surgery (_____)
☐ Valve Replacement/Repair (_____)
☐ Weight Loss Surgery (_____)

☐ Other (Please list): _____
_____

Family History–Check all that apply

Relationship	First Name	Status (circle)	No Known Problems	Arthritis	Asthma	Birth Defects	Cancer	Clotting Disorder	Depression	Diabetes	Early Sudden Death	Hearing Loss	Heart Disease	Hypertension	Kidney Problems	Mental Illness	Stroke	Substance /Drug Abuse	Vision Loss	Other:
Mother		alive deceased																		
Father		alive deceased																		
Maternal Grandmother		alive deceased																		
Maternal Grandfather		alive deceased																		
Paternal Grandmother		alive deceased																		
Paternal Grandfather		alive deceased																		
Brother		alive deceased																		
Sister		alive deceased																		
Maternal Aunt		alive deceased																		
Maternal Uncle		alive deceased																		
Paternal Aunt		alive deceased																		
Paternal Uncle		alive deceased																		
Other:		alive deceased																		

****Type of Cancer or Disease:** _____

Screening

In the past two weeks, how often have you been bothered by the following? (Please circle one response per statement.)

Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly every day

Have you fallen in the past year? ☐ Yes ☐ No
Are you afraid of falling? ☐ Yes ☐ No
Do you have issues with balance or feeling unsteady? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No

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Health Maintenance

		Yes	No		
Women	Menstrual Period	☐	☐	Last _____	# of pregnancies _____ # deliveries _____
				Menstrual Problems: ☐ Yes ☐ No _____	
				Vaginal Discharge: ☐ Yes ☐ No _____	
				Irritation or Abnormal Bleeding: ☐ Yes ☐ No _____	
	Pap Smear	☐	☐	When _____	Abnormal? _____
	Mammogram	☐	☐	When _____	Abnormal? _____
General	Colonoscopy	☐	☐	When _____	Where _____
	Dexa/Bone Density	☐	☐	When _____	Where _____
	Eye Exam	☐	☐	When _____	Where _____
	Dental Exam	☐	☐	When _____	Where _____

Immunizations

Tetanus or TDAP	☐	☐	When _____	Where _____
Flu	☐	☐	When _____	Where _____
Pneumovax	☐	☐	When _____	Where _____
Prevnar	☐	☐	When _____	Where _____
Zostavax (Shingles)	☐	☐	When _____	Where _____

Review of Systems (current symptoms) – please check only if these are bothering you at this time

Gastrointestinal
☐ Poor Appetite ☐ Nausea ☐ Vomiting ☐ Heartburn/Indigestion ☐ Rectal Bleeding
☐ Stomach Pain ☐ Constipation ☐ Vomiting Blood ☐ Black Tarry Stools ☐ Other: _____
☐ Diarrhea ☐ Abdominal Swelling ☐ Trouble Swallowing ☐ Other: _____ ☐ Other: _____

Constitutional ☐ Fevers ☐ Fatigue ☐ Weight Gain ☐ Weight Loss

Head / Eyes ☐ Cataracts ☐ Dry Eyes ☐ Poor Vision ☐ Color Blindness

Ears/Nose/Mouth/Throat
☐ Hearing Loss ☐ Chronic Sinus Congestion
☐ Heavy Snoring ☐ Bad Teeth

Respiratory (lungs)
☐ Cough ☐ Asthma
☐ Shortness of Breath ☐ Emphysema (COPD)

Heart ☐ Chest Pain ☐ Palpitations ☐ Irregular Heart Beat ☐ High Blood Pressure

Genitourinary ☐ Sexual Problems ☐ Burning with Urination ☐ Blood in Urine ☐ Leakage of Urine

Muscles/Bones ☐ Chronic Pain ☐ Arthritis ☐ Bone Pain ☐ Muscle Weakness ☐ Muscle Cramping ☐ Joint Pain

Skin ☐ Rash ☐ Jaundice ☐ Itching ☐ Psoriasis

Neurological ☐ Headaches ☐ Seizures (Epilepsy) ☐ Confusion ☐ Tremor (shaking)

Vascular ☐ Blood Clots ☐ Varicose Veins

Psychosocial
☐ Anxiety / Nerves ☐ Abusive Relationship ☐ Sexual Problems ☐ Sleep Problems ☐ Alcohol Use
☐ Depression ☐ Feeling Worthless ☐ Want to Hurt Yourself ☐ Want to Hurt Others ☐ Drug Use

Endocrine ☐ Hot Flashes ☐ Bothered by Heat ☐ High Thirst ☐ Bothered by Cold

Blood / Lymph ☐ Swollen Lymph Nodes ☐ Easy Bruising ☐ Easy Bleeding