Wayne County Healthy Communities
PATIENT HISTORY FORM

Please complete all areas to the best of your knowledge

NAME:	DATE:
MARITAL STATUS: Single / Married / Divorced / Widowed / Separated	OCCUPATION:
EDUCATION LEVEL: 0-12 / High School Diploma / 13, 14, 15, 16, 17 , 18	
DO YOU HAVE A LIVING WILL: YES NO	

Address

Listed below are common medical conditions. If either ***YOU*** or a ***FAMILY MEMBER*** has now or has ever had in the past any of these conditions, ***PUT A √ IN THE BOX*** then, next to the problem, list the relationship of the person who had the problem.

CONDITION	FAMILY MEMBER	CONDITION	FAMILY MEMBER
☐ Breast Cancer		☐ Hepatitis	
☐ Cervical Cancer		☐ Arthritis	
☐ Prostrate Cancer		☐ Back Problems	
☐ Colon Cancer		☐ Hearing Problems	
☐ Skin Cancer		☐ Dental Problems	
☐ Other Cancer		☐ Skin Problems	
☐ Heart Attack		☐ Kidney Problems	
☐ Heart Surgery		☐ Change in Bowel Habits	
☐ Leg Swelling		☐ Blood in Stool	
☐ Stroke		☐ Dark Tarry Stool	
☐ High Cholesterol		☐ Sexually transmitted Disease	
☐ Diabetes		☐ Tuberculosis	
☐ High Blood Pressure		☐ Chicken Pox	
☐ Emphysema / COPD		☐ Migraine Headaches	
☐ Asthma		☐ Seizures	
☐ Sickle Cell / Trait		☐ Bleeding Disorder	

Please list month and year of your most recent

Hepatitis A	____/____	Measles	____/____	Chicken Pox	____/____
Hepatitis B	____/____	Pneumonia *	____/____	Other:	
Flu Shot **	____/____	Tetanus *	____/____		

* *Recommended every 10 years* ** *Recommended every year*

For ***WOMEN*** please fill in the following information:

Number of pregnancies: _____	# of children _____	# of miscarriages _____	# of abortions _____
Age at first period _____	Age of menopause _____		
Date of last period		Could you be pregnant now?	YES NO
Method of birth control:			
Last Pap Smear / Female Exam		Have you had an abnormal Pap Smear?	YES NO
Last Mammogram		Have you had an abnormal mammogram	YES NO

For ***MEN*** please fill in the following information:

Last PSA (blood prostrate level)	*(Screening may begin at age 50)*
√ if you have:	▯ Weak urine stream ▯ Lumps on testicles ▯ Pain on testicles ▯ Prostrate problems

For ***Men and Women*** please fill in the following information:

Last Rectal Exam	*(Recommended yearly after age 50)*
Last Flexible Sigmoidoscopy	*(Recommended every 3-5 years after age 50)*

Please list all ***medications*** you are on, including over the counter, vitamins, herbal supplements, and contraception

****PLEASE COMPLETE THE BACK OF THIS SHEET****

Please list all medications you are allergic to and what happens. If you have NO allergies √ this box ☐ NONE

Please list any *surgeries* you have ever had

System Review: Please list problems you have with any of the following:

☐ Eyes	☐ Ear / Nose / Throat
☐ Heart	☐ Lungs
☐ Chest	☐ Breasts
☐ Abdomen	☐ Genitals
☐ Skin	☐ Joints / Back
☐ Arms / Legs	☐ Neurologic

Please √ if you have now or have had in the past any of the habits listed below

Habit	What Type	Habit	What Amount
☐ Illicit Drugs		☐ Caffeine	
☐ Alcohol		☐ Regular Exercise	
☐ Tobacco		☐ Use Seat Belts	

Please √ the appropriate reply	YES	NO
Have you often been bothered by feeling down, depressed or hopeless?		
Have you often been bothered by little interest or pleasure in doing things?		
Have you ever experienced severe uncontrollable mood swings?		
Are you bothered by frequent dreams or memories of a traumatic event?		
Have you ever felt you ought to cut down on your drinking or drug use?		
Have people annoyed you by criticizing your drinking or drug use?		
Have you ever felt excessively anxious or panicked for no apparent reason?		
Have you ever had a drink or used drugs first thing in the morning?		
Have you been hit, kicked, punched or otherwise hurt by someone in the past year?		
Does your current partner or partner from a previous relationship make you feel unsafe?		
Have you had more than five drinks in one day in the past three months?		
Have you ever been diagnosed with mental retardation or a developmental disability?		
Do you have any concerns about your child's behavior or performance in school?		
Do you have any concerns related to your ability to work?		

I would rate my overall health as: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Your signature below indicates that you have read and answered all of the questions to the best of your knowledge.

Thank you.

Patient Signature: _____ ***Date:*** _____

BELOW FOR USE BY WCHC STAFF

Nurse Review: ☐ Information reviewed with patient

Nurse (Print): _____ Signature: _____

RECOMMENDATIONS:

☐ Set up *initial visit* with Primary Care Physician / Clinic
☐ Preventative Health Screening (list specific screening needed) _____
☐ Evaluation of _____ (list history of symptoms of concern)
☐ Nutrition Assessment
☐ Mental Health Evaluation
☐ Other _____

Physician Review: ☐ Information reviewed with patient

Physician (Print) : _____ Signature: _____