

**WASSAJA MEMORIAL HEALTH CENTER**  
**PATIENT HEALTH HISTORY (Page 1)**

*Please complete the following information to the best of you knowledge.*

**I. PATIENT INFORMATION:**

Name of Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

What is the reason/problem that brought you here today? \_\_\_\_\_

**II. MEDICAL HISTORY:**

Please list all medications you are **currently** taking. Including over the counter AND any herbal/vitamin supplements (such as St. John's Wort, Metabolife, etc.):

List ANY allergies you have to food or medications: \_\_\_\_\_

**III. PAST MEDICAL / FAMILY HISTORY:**

Please indicate any of the following illnesses you or any of your blood relatives have had by checking the box of any that apply:

	I HAD	RELATIVE HAD		I HAD	RELATIVE HAD
1. Chicken Pox			16. Sexually Transmitted Disease		
2. Measles			17. Tumor or Cancer		
3. Mumps			18. Anemia		
4. Rheumatic Fever			19. Intestinal Ulcers		
5. Tuberculosis			20. Glaucoma or Cataracts		
6. Thyroid Disease			21. Alcohol Problem		
7. Asthma			22. Stroke		
8. Diabetes			23. Pneumonia		
9. Epilepsy or Convulsions			24. Gall Bladder Disease		
10. Arthritis			25. Depression		
11. Heart Disease			26. Hypertension/High Blood Pressure		
12. Lung Disease			27. HIV Infection/AIDS		
13. Hepatitis or Jaundice			28. Skin disease		
14. Kidney/Bladder Infection or Stone			29. Bronchitis		
15. Mental/Nervous Condition			30. Allergies/Hay Fever		

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PATIENT HISTORY FORM (Page 2)**

**IV. PAST HOSPITALIZATIONS & SURGERIES:**

Please list your most recent hospitalization and/or surgeries. Include the dates and reason(s) for hospital stay, (tonsillectomy, appendectomy, hernia, C-section, etc.)

YEAR	OPERATION/ILLNESS	HOSPITAL

**V. PREGNANCY HISTORY:**

**YES      NO      N/A**

- |   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
| 1. Are you pregnant now?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been pregnant?                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| # of pregnancies _____ # of miscarriages _____ # of abortions _____ |                          |                          |                          |
| 3. Current birth control method _____                               |                          |                          |                          |

**VI. SOCIAL HEALTH HISTORY:**

**YES                      NO**

- |   |                          |                          |
|---|--------------------------|--------------------------|
| 1. Do you currently smoke cigarettes OR have you ever smoked cigarettes?<br>If <u>YES</u> , how many packs per day? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you drink alcoholic beverages?<br>If <u>YES</u> , how much and how often? _____                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have a regular exercise program?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you wear a seatbelt when driving or riding in an automobile?  | <input type="checkbox"/> | <input type="checkbox"/> |

Please include any other information you think would be helpful for us to know: \_\_\_\_\_

**VII. SYSTEM REVIEW:**

Which of these symptoms have you had or currently experience on a regular basis? *Check ALL that apply.*

Symptom	X	Symptom	X
1. Heartburn or acid backwash into mouth		10. Fatigue	
2. Breathing problems (cough, shortness of breath)		11. Muscle aches/pains	
3. Swallowing problems (food gets stuck or painful)		12. Joint pain/swelling	
4. Headache		13. Bleeding from rectum	
5. Vision changes (blurry or double)		14. Painful menstrual periods	
6. Difficulty hearing		15. Heavy or irregular periods	
7. Chest pain or chest discomfort		16. Painful or frequent urination	
8. Abdominal pain		17. Difficulty urinating or controlling flow	
9. Nausea/Vomiting			