PACIFIC NORTHWEST PRIMARY CARE
Health Appraisal Form

PLEASE PRINT

Today's Date_____

Name:_____
Last First Middle

Date of Birth:_____ (age) __

Past Medical History

Home Phone:_____

Surgeries/Dates

Type of Work:_____

Marital Status:_____

Highest Education:_____

Previous Health Provider:_____

_____

_____

_____

_____

_____

Medical Problems/Hospitalizations/ Major Illness/Injuries

Immunization History/Date Done

_____

_____

_____

_____

_____

Tetanus:_____

TB Skin Test:_____Results:_____

Influenza Vaccine:_____Measles_____

Pneumonia Vaccine:_____

Hepatitis B Series:_____

Hepatitis A Series:_____

Gardisil Series:_____

DRUG ALLERGIES & REACTION

_____

_____

Family History **Age** **Health Status or Cause of Death**

Father		
Mother		
Siblings		
Children		

List Any Relatives With the Following:

Depression/ Mental Illness_____

Diabetes_____

Heart Problems_____

Heart Attack_____

High Blood Pressure_____

High Cholesterol_____

Cancer_____

Obesity_____

Thyroid Disorder_____

Smoker No Yes Age Started_____ Pack Per Day_____ Quit Y N How Long_____

Marijuana No Yes Age Started_____ Per Day_____ Quit Y N How Long_____

Alcohol No Yes Type_____ Amount _____ Any DUI Y N Any Alcohol Concerns Y N

Caffeine Use Types_____ Amount/Day Seatbelt use: Y N

Activity Level (check one or more boxes)

Illegal drugs ever used: Y N When:_____

☐ Sedentary with little exercise

What: _____

☐ Mild exercise with job, house or recreation (climb stairs, walk over 3 blocks, golf, bowl, etc.)

☐ Occasional vigorous activity with work or recreation Diet type_____

☐ Regular Vigorous exercise program or hard work

COMPLETE REVERSE

Circle if you have had of the following symptoms to an unusual or significant degree

Vision problems glaucoma wear glasses

Hearing problems right_____ left_____ chronic earaches ear tubes

Sinus problems frequent colds hay fever nose bleeds

Cough wheezing asthma bronchitis TB _____ pneumonia shortness of breath COPD

Dizziness fainting seizures headaches numbness

Chest pain heart murmur racing heart irregular heartbeat high blood pressure high cholesterol or triglycerides

Arthritis back pain joint pain/swelling muscle cramps ankle swelling fluid retention

Varicose veins phlebitis calf pain with walking

Diarrhea constipation heartburn reflux irritable bowel

Diabetes low blood sugar high blood sugar thyroid problems autoimmune disorder_____

Kidney trouble frequent urinary infections difficulty urinating sugar in urine blood in urine prostate trouble hernia

Infertility impotence or sexual dysfunction irregular menses polycystic ovaries

Sleep disorder snoring difficulty concentrating memory problems depression anxiety suicidal thoughts

Name of specialist involved in your care:

OB/GYN_____ Cardiologist_____

Pulmonary_____ Rheumatologist_____

Neurologist_____ Endocrinologist_____

Orthopedist_____ Naturopath_____

Chiropractor_____ Other_____

Men Over 45

Last PSA checked _____

Women Only

Age at first Menstruation_____ Menstrual Problems_____

Date of last PAP_____ Any history of abnormal PAP: Y N ☐ HPV: ☐ Y ☐ N

Date of last mammogram_____ Where was it done?_____

Number of pregnancies_____ Number of Live Births_____ Age at first full term pregnancy_____

Birth Control Method_____ Do you do self breast exams? Never Occasionally Monthly

Hysterectomy_____ Ovaries present? ☐ Y N ☐ Hormone Type/Dose_____

Naturopathic or OTC Women's Support Meds:_____