HEALTH HISTORY

Today's Date:	Patient Name:

SOCIAL HISTORY

Do you drink alcohol?

- ○ No, None
- ○ Yes, less than 2 drinks weekly
- ○ Yes, 1-2 drinks daily
- ○ Yes, more than 2 drinks daily

Do you use recreational Drugs?

- ○ No
- ○ Yes, please indicate type/s below and length of use:

_____

Do you now or have you ever used any type of tobacco products?

- ○ No, never
- ○ Yes, cigarettes: ___ pack per day, X____years
- ○ Yes, chewing tobacco: X _____ years
- ○ Yes, for _____ years, Quit year: _____

Do you feel safe at home?	Do you live alone?	Other providers involved in your care:	Location of other providers if not local:
☐ YES ☐ NO	☐ YES ☐ NO	Name:	

CURRENT MEDICATIONS

Do you currently take any type of medication, supplement, vitamins or over the counter medications?

Medication name	Dosage	Frequency	Reason for taking:

ALLERGIES

☐ I have no drug allergies or intolerances ☐ I have food/environmental allergies only (List allergies)_____

I am allergic to:	Reaction:

PREFERRED PHARMACY

Pharmacy Name: ☐ Island Pharmacy ☐ Wal-Mart Pharmacy ☐ Safeway Pharmacy ☐ Other: _____

PREFERRED LABORATORY

Laboratory Name: ☐ Quest Diagnostics ☐ Peacehealth Ketchikan Medical Center ☐ I have no preference

HEALTH HISTORY

FEMALE PATIENTS

Last menstrual Period: _____/ _____/ _____ Lasting _____ Days

Date of last pap smear: _____/ _____/ _____ Where?:_____ ☐ Normal ☐ Abnormal (Date:_____)

Number of pregnancies: _____, Completed: _____, Premature: _____, Miscarriages: _____, Terminations: _____, Living Children: _____

Have you ever had a Mammogram?	Have you ever had a bone density scan?	Have you ever had a colonoscopy?
☐ Yes, Date: _____ ☐ No	☐ Yes, Date:_____ ☐ No	☐ Yes, Date: _____ ☐ No

MALE PATIENTS

Last Prostate exam:	Abnormal Prostate?	Have you ever had a colonoscopy?
Date:	☐ Yes, Date: _____ ☐ No	☐ Yes, Date: _____ ☐ No

MAJOR EVENTS

Have had surgery? ☐ Yes, list below ☐ No Have you ever spent the night in a hospital? ☐ Yes, list below ☐ No

Surgery:	Year:	For:	Where?
Surgery:	Year:	For:	Where?
Surgery:	Year:	For:	Where?
Surgery:	Year:	For:	Where?
Surgery:	Year:	For:	Where?

HEALTH HISTORY

Have **you** or anyone in your **family** been diagnosed or treated for:

Illness	Me	Family member (Specify who)	Illness:	Me	Family member (specify who)
Stroke:			Diabetes:		
Chest pain:			Emphysema/COPD:		
Irregular health beat:			Asthma:		
High blood pressure:			Glaucoma:		
High cholesterol:			Rheumatoid Arthritis:		
Heart Murmur:			Autoimmune Diseases:		
Head Injury:			Lupus:		
Multiple Sclerosis:			*Cancer: *If yes, specify type		
Seizures:			Kidney Disease:		
Acid reflux/GERD:			Prostate abnormalities:		
Diverticulitis:			Herpes:		
Colitis/Chron's disease:			Blood clotting condition:		
Hepatitis:			Anemia:		
Gall bladder trouble:			*Mental Illness:		
Thyroid Disease:			*If yes, specify type:		