MEDICAL HISTORY FORM AND HEALTH RISK PROFILE ACCESSHEALTH

DATE_____
MR. NO._____

Name _____ Birthdate _____

Drug and/or Medication Allergies _____ Sex: Male ☐ Female ☐

**I. CONDITIONS: Please place a check in the box next to a condition you have currently or in the past, and indicate month/year of onset in the line next to it. Leave all others BLANK.**

**CONDITION** **Date**

*Metabolic/Hormonal Disorders*
- ☐ Cholesterol dis. _____
- ☐ Diabetes _____
- ☐ Gout _____
- ☐ Menopause _____
- ☐ Thyroid problems _____
- ☐ Other (list below) _____

_____

*Ears, eyes, nose, and throat*
- ☐ Cataracts _____
- ☐ Glaucoma _____
- ☐ Deaf _____
- ☐ Blind _____
- ☐ Allergies _____
- ☐ Other (list below) _____

_____

*Stomach and Digestive disorders*
- ☐ Colitis _____
- ☐ Hemorrhoids _____
- ☐ Reflux/Esophagitis _____
- ☐ Gastritis/Ulcers _____
- ☐ Gallstones _____
- ☐ Pancreatitis _____
- ☐ Diverticulosis _____
- ☐ Other (list below) _____

_____

*Autoimmune and Skin disorders*
- ☐ Acne _____
- ☐ Eczema _____
- ☐ Keloids _____
- ☐ Psoriasis _____
- ☐ Rosacea _____
- ☐ Lupus _____
- ☐ Scleroderma _____
- ☐ Other (list below) _____

_____

**CONDITION** **Date**

*Heart and Circulation Disorders*
- ☐ Angina _____
- ☐ Blood clots _____
- ☐ High blood pressure _____
- ☐ Heart attack _____
- ☐ Heart failure _____
- ☐ Heart murmur _____
- ☐ Stroke _____
- ☐ Other (list below) _____

_____

*Kidney and Bladder disorders*
- ☐ Kidney stones _____
- ☐ Kidney failure _____
- ☐ Prostate problems _____
- ☐ Frequent infections _____
- ☐ Other (list below) _____

_____

*Bone and Joint disorders*
- ☐ Amputations _____
- ☐ Arthritis _____
- ☐ Bone or joint infection _____
- ☐ Osteoporosis _____
- ☐ Other (list below) _____

_____

*Cancers*
- ☐ Cervix _____
- ☐ Colon _____
- ☐ Head and neck _____
- ☐ Leukemia _____
- ☐ Lung _____
- ☐ Lymphoma _____
- ☐ Prostate _____
- ☐ Uterus _____
- ☐ Melanoma _____
- ☐ Other (list below) _____

_____

**CONDITION** **Date**

*Infections*
- ☐ AIDS/HIV _____
- ☐ Chlamydia _____
- ☐ Gonorrhea _____
- ☐ Herpes _____
- ☐ Hepatitis B _____
- ☐ Hepatitis C _____
- ☐ Rheumatic fever _____
- ☐ Syphilis _____
- ☐ Tuberculosis _____
- ☐ Other (list below) _____

_____

*Blood or clotting disorders*
- ☐ Anemia _____
- ☐ Bleeding problems _____
- ☐ Transfusion _____
- ☐ Other (list below) _____

_____

*Lung disorders*
- ☐ Asthma _____
- ☐ Bronchitis/COPD _____
- ☐ Emphysema _____
- ☐ Other (list below) _____

_____

*Mental and Nerve disorders*
- ☐ Anxiety _____
- ☐ Dementia _____
- ☐ Depression _____
- ☐ Epilepsy/seizure _____
- ☐ Meningitis _____
- ☐ Migraine _____
- ☐ Multiple sclerosis _____
- ☐ Parkinson's _____
- ☐ Severe head injury _____
- ☐ Other (list below) _____

_____

Medications (list any supplements, OTCs, and/or prescriptions you are currently taking)

_____

_____

**II. SUGERIES AND MAJOR PROCEDURES: Please place a check in the box next to a surgery or procedure you had done, and indicate month/year done on the line. Leave all others BLANK.**

*Surgical Removal*
- ☐ Appendix _____
- ☐ Kidney _____
- ☐ Stomach _____
- ☐ Tonsils _____
- ☐ Gallbladder _____
- ☐ Spleen _____
- ☐ Thyroid _____
- ☐ Uterus/womb _____
- ☐ Breast _____

*Surgical Procedure*
- ☐ Tubes tied _____
- ☐ Vasectomy _____
- ☐ Plastic surgery _____
  Specify type: _____
- ☐ Back/joint _____
  Specify joint: _____

*Cardiovascular Procedure*
- ☐ Cardiac catheter _____
- ☐ Coronary stent _____
- ☐ Coronary bypass _____

Other surgeries/Procedures _____

## III. REVIEW OF SYSTEMS: Please check the symptoms you have. Leave all others BLANK.

| | | |
|---|---|---|
| ☐ Unexplained weight loss | ☐ Recurrent fever | ☐ Night sweats |
| ☐ Persistent headaches | ☐ Recurrent sore throat | ☐ Persistent chest pain |
| ☐ Persistent cough | ☐ Cough blood | ☐ Breast lumps |
| ☐ Sores that won't heal | ☐ Moles that changes | ☐ Recurrent belly pain |
| ☐ Blood in bowels | ☐ Vomited blood | ☐ Persistent diarrhea |
| ☐ Blood in urine | ☐ Lose urine or slow urine | ☐ Abnormal vaginal bleed |
| ☐ Loss of consciousness | ☐ Problems w/erection | ☐ Loss of vision |
| ☐ Lumps in testicles | ☐ Paralysis of any part | ☐ Suicidal thoughts |

## IV. FAMILY HISTORY: Please indicate which illnesses and which family member is/was affected by checking the box for the family member and illness in the table below. For any cancers, please list the type in the space provided. (M=Mother, F=Father, S=Sibling, MGM=Maternal Grandmother, MGF=Maternal Grandfather, PGM=Paternal Grandmother, PGF=Paternal Grandfather)

| | M | F | S | MGM | MGF | PGM | PGF |
|---|---|---|---|---|---|---|---|
| Alcoholism | | | | | | | |
| Asthma | | | | | | | |
| Bleeding disorders | | | | | | | |
| Diabetes | | | | | | | |
| Epilepsy | | | | | | | |
| Heart disease | | | | | | | |
| High blood pressure | | | | | | | |
| Kidney disease | | | | | | | |
| Mental illness | | | | | | | |
| Migraine | | | | | | | |
| Osteoporosis | | | | | | | |
| Stroke | | | | | | | |
| Thyroid disease | | | | | | | |
| Suicide | | | | | | | |
| Cancer Type: | | | | | | | |

Does your spouse/partner or close family member have?

☐ HIV ☐ Tuberculosis (TB) ☐ Hepatitis B ☐ Hepatitis C

## V. IMMUNIZATION HISTORY: Please indicate which vaccines you have had as an adult, with dates.

| | | | |
|---|---|---|---|
| ☐ Tetanus | ☐ Pneumonia/Pneumovax | ☐ Varicella (Chickenpox) | ☐ Herpes Zoster (Shingles) |
| ☐ Hepatitis A | ☐ Hepatitis B | ☐ MMR | ☐ HPV |

Have you ever had a positive TB skin test? Please circle: Yes/No

If yes, when? _____ If no, date of last negative? _____

## VI. SOCIAL HISTORY

Highest level of education: _____

Occupation: _____

Marital Status: Please circle one: single/married/divorced/separated/widowed

Are you sexually active? Please circle: Yes/No

If yes, how many partners? _____

If yes, is partner of same sex? _____

If yes, does partner practice needle drug use? _____

If yes, did partner have sex with someone of same sex? _____

In the past year, were you hit, slapped, kicked, pushed, or otherwise physically hurt by someone? Please circle: Yes/No

In the past year, has anyone forced you to have sexual activities? Please circle: Yes/No

## VII. LIFESTYLE: Please indicate any of the following habits you may have and answer the corresponding questions

☐ Smoking. Amount? _____ How long? _____ If you had quit, when did you quit? _____

☐ Chew/Dip (tobacco)

☐ Alcohol. How many drinks per day? _____ How many drinks per week? _____

☐ Recreational drugs. Specify type(s): _____ If you had quit, when did you quit? _____

☐ Regular exercise. Specify type(s): _____ How often? _____

☐ Brush teeth daily ☐ Wear sunscreen ☐ Wear seat belts ☐ Secure guns/ammo

**The answers provided above is the history that I want my provider to know about. Any blank responses are purposefully left blank**

**Patient signature: _____ Date: _____**

**Physician/Provider signature: _____ Date: _____**

WOMEN AND MENS HEALTH FORM ACCESSHEALTH

DATE_____
MR. NO. _____

Name _____ Birthdate _____

**Directions: please answer the questions in the section based on your biological gender.**

WOMENS HEALTH:

When was your latest mammogram? _____
What was your last mammogram's results? Please circle: Normal/Abnormal
When was your last pap smear? _____
What was your last pap smear's results? Please circle: Normal/Abnormal
At what age did you start having your period? _____ When was your last period? _____
Age at menopause: _____
Number of pregnancies: Number of abortions: Number of miscarriages: Living children:
Maternal substance use:
□ Yes. If yes, what did you use? _____ □ No.
Blood exposure/Transfusion:
□ Yes. If yes, when? _____ □ No.
Are you currently on birth control?
□ Yes. If yes, what do you use? _____ □ No.

MENS HEALTH:

When was your latest prostate exam? _____
What was your last prostate exam's results? Please circle: Normal/Abnormal
Do you have any problems with urination? Please circle: Yes/No
Do you have any problems with obtaining an erection? Please circle: Yes/No

**The answers provided above is the history that I want my provider to know about. Any blank responses are purposefully left blank**

**Patient signature: _____ Date: _____**
**Physician/Provider signature: _____ Date: _____**

---

***THE FOLLOWING IS TO BE FILLED OUT BY THE PROVIDER***

RISK MANAGEMENT PLAN: Review of history indicates need for intervention in (enter date and initial):

| | DATE | INITIAL | DATE | INITIAL | DATE | INITIAL |
|---|---|---|---|---|---|---|
| 1. Cardiovascular risk | | | | | | |
| 2. Immunization update | | | | | | |
| 3. Substance abuse | | | | | | |
| 4. STD Prevention | | | | | | |
| 5. Safety/Violence | | | | | | |
| 6. Exercise/Nutrition | | | | | | |
| 7. Preventive Health Issues | | | | | | |
| 8. Medical History Update | | | | | | |