Kimball Health Services
CARING...close to home
505 S Burg St.
Kimball, NE 69145

Internal Medicine
Health History Questionnaire

Pine Bluffs Health Clinic
117 E 4th St. (307) 245-3666
117 E 4th St.
Pine Bluffs, WY 82082

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. **ALL QUESTIONS CONTAINED IN THIS QUESTIONARE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.**

Main Concerns for today's visit: _____

Other Concerns: _____

Allergies:

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY:	**REACTION:**
1. _____	_____
2. _____	_____
3. _____	_____

Preferred Pharmacy: _____

Please list all the medication(s) you are taking. Include prescriptions drugs and over-the-counter such as vitamins and inhalers.

DRUG NAME	**STRENGTH:**	**FREQUENCY TAKEN:**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

□ Chickenpox	Date: _____	□ Meningococcal	Date: _____
□ Flu Shot	Date: _____	□ MMR (Measles, Mumps, Rubella)	Date: _____
□ Gardasil/HPV	Date: _____	□ Pneumonia	Date: _____
□ Hepatitis A	Date: _____	□ Tdap (Tetanus & Pertussis	Date: _____
□ Hepatitis B	Date: _____	□ Tetanus	Date: _____
		□ Zostavax (Shingles)	Date: _____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL

Last PAP Smear Date: _____ □ Abnormal

Last Mammogram Date: _____ □ Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of pregnancies _____ Births _____

Miscarriages _____ Abortions: _____

□ Cesarean sections If yes, then number: _____

□ Bleeding between periods
□ Heavy periods
□ Extreme menstrual periods
□ Vaginal itching, burning, or discharge
□ Wake in the night to go to the bathroom
□ Hot flashes
□ Breast lump or nipple discharge
□ Painful intercourse
□ Sexually active

Current sexual partner is: □ Male □ Female

Do you use condemns? □ Yes □ No

Other birth control method used: _____

□ Interested in being screened for STD's.

Past Medical History

Please check all that apply:

- ◻ Anxiety Disorder
- ◻ Arthritis
- ◻ Asthma
- ◻ Bleeding Disorder
- ◻ Blood Clots (or DVT)
- ◻ Cancer
- ◻ Coronary Artery Disease
- ◻ Claustrophobic
- ◻ Diabetes - Insulin
- ◻ Diabetes - Non -Insulin
- ◻ Dialysis
- ◻ Colon Cancer Screening Date: _____
- ◻ Diverticulitis
- ◻ Fibromyalgia
- ◻ Gout
- ◻ Has Pacemaker
- ◻ Heart Attack
- ◻ Heart Murmur
- ◻ Hiatal Hernia or Reflux Disease
- ◻ HIV or AIDS
- ◻ High Cholesterol
- ◻ High Blood Pressure
- ◻ Overactive Thyroid
- ◻ Kidney Disease
- ◻ Kidney Stones
- ◻ Leg / Foot Ulcers
- ◻ Liver Disease
- ◻ Osteoporosis
- ◻ Polio
- ◻ Pulmonary Embolism
- ◻ Reflux or Ulcers
- ◻ Stroke
- ◻ Tuberculosis
- ◻ Other: _____

Past Surgical History

Surgery	Reason	Year	Facility
1.			
2.			
3.			
4.			

Family Health History

Relation	Alive:	Age:	Significant Health History
Grandmother (Maternal)	Y/N	_____	◻ Heart Disease ◻ Hypertension ◻ Osteoporosis ◻ Stroke ◻ Alcoholism ◻ Arthritis ◻ Depression ◻ Cancer ◻ Diabetes ◻ Genetic Disease
Grandfather (Maternal)	Y/N	_____	◻ Heart Disease ◻ Hypertension ◻ Osteoporosis ◻ Stroke ◻ Alcoholism ◻ Arthritis ◻ Depression ◻ Cancer ◻ Diabetes ◻ Genetic Disease
Grandmother (Paternal)	Y/N	_____	◻ Heart Disease ◻ Hypertension ◻ Osteoporosis ◻ Stroke ◻ Alcoholism ◻ Arthritis ◻ Depression ◻ Cancer ◻ Diabetes ◻ Genetic Disease
Grandfather (Paternal)	Y/N	_____	◻ Heart Disease ◻ Hypertension ◻ Osteoporosis ◻ Stroke ◻ Alcoholism ◻ Arthritis ◻ Depression ◻ Cancer ◻ Diabetes ◻ Genetic Disease
Mother	Y/N	_____	◻ Heart Disease ◻ Hypertension ◻ Osteoporosis ◻ Stroke ◻ Alcoholism ◻ Arthritis ◻ Depression ◻ Cancer ◻ Diabetes ◻ Genetic Disease
Father	Y/N	_____	◻ Heart Disease ◻ Hypertension ◻ Osteoporosis ◻ Stroke ◻ Alcoholism ◻ Arthritis ◻ Depression ◻ Cancer ◻ Diabetes ◻ Genetic Disease
Brother/Sister	Y/N	_____	◻ Heart Disease ◻ Hypertension ◻ Osteoporosis ◻ Stroke ◻ Alcoholism ◻ Arthritis ◻ Depression ◻ Cancer ◻ Diabetes ◻ Genetic Disease
Brother/Sister	Y/N	_____	◻ Heart Disease ◻ Hypertension ◻ Osteoporosis ◻ Stroke ◻ Alcoholism ◻ Arthritis ◻ Depression ◻ Cancer ◻ Diabetes ◻ Genetic Disease
Other: _____		_____	◻ Heart Disease ◻ Hypertension ◻ Osteoporosis ◻ Stroke ◻ Alcoholism ◻ Arthritis ◻ Depression ◻ Cancer ◻ Diabetes ◻ Genetic Disease

Social History - All

Habits:

Exercise Routine: ◻ None ◻ Infrequently ◻ Frequently ◻ Daily

Exercise Frequency: _____ ◻ Times per Day ◻ Times per Week ◻ Times per Month

Type of Exercise: ◻ Aerobic ◻ Non-aerobic ◻ Strength Training ◻ Walking ◻ Running ◻ Swimming ◻ Yoga/Stretching ◻ Team Sport ◻ Other _____

Caffeine:

Coffee: _____ 6 oz. Servings Per Day

Tea: _____ 6 oz. Servings Per Day

Soda / Pop: _____ 12 oz. Servings Per Day

Tobacco Use Screening Completed:
Screening Status: ◻ Yes ◻ No Date:_____
Reason for not screening: _____

Smoked Tobacco: Start Date: _____ Stop Date: _____
Smoking Status: ◻ Current every day smoker ◻ Current some day smoker ◻ Former smoker ◻ Never Smoked
◻ Heavy tobacco smoker ◻ Light tobacco smoker ◻ Unknown if ever smoked

Frequency: _____ Packs per: ◻ Day ◻ Week ◻ Year
Cigarettes: _____ Years Cigars: _____ Years Pipe: _____ Years

Smokeless Tobacco: Start Date: _____ Stop Date: _____
Smokeless Tobacco Status: ◻ Does not use moist powdered tobacco ◻ Never used moist powdered tobacco
◻ Ex-user of moist powdered tobacco ◻ Never chewed tobacco
◻ Snuff user ◻ User of moist powdered tobacco ◻ Chews tobacco
Frequency: _____ Uses times per: ◻ Day ◻ Week ◻ Year

Duration: _____ Years

Electronic Cigarettes: Start Date: _____ Stop Date: _____
Electronic Cigarette use: ◻ Yes ◻ No

Duration: _____ Years

Tobacco Cessation Counseling:
Counseling given: ◻ Yes ◻ No
Cessation Counseling Given: ◻ Yes ◻ No
Reason Not Given: ◻ Medical ◻ Patient Refused ◻ Other: _____

Alcohol: Start Date: _____ Stop Date: _____
Use: ◻ Never ◻ Rare ◻ Occasional ◻ Frequent ◻ Binge Drinker ◻ In Recovery ◻ Quit ◻ Abuse History
Type: ◻ Beer ◻ Wine ◻ Liquor
Frequency: _____ ◻ Drinks per Day ◻ Drinks per week ◻ Drinks per Month
Duration: _____ Years

Substance Abuse: Start Date: _____ Stop Date: _____
Use: ◻ Never ◻ Rare ◻ Occasional ◻ Frequent ◻ Addiction ◻ Recovering Addiction
Usage Routes: ◻ Oral ◻ Smoking ◻ Intranasal ◻ Inhalation ◻ Subcutaneous ◻ Intravenous ◻ Other: _____
Type: ◻ Cocaine ◻ Methamphetamine ◻ Heroin ◻ Marijuana ◻ Prescription Drug Abuse ◻ Other: _____
Frequency: _____ ◻ Times per Day ◻ Times per week ◻ Times per Month For _____ years

Environmental History:
Relationship Status: ◻ Single ◻ Married ◻ Divorced ◻ Separated ◻ Widowed ◻ Significant Other
Domestic Violence: ◻ Yes ◻ No
Occupational History: ◻ Full Time ◻ Part Time ◻ Homemaker ◻ Retired ◻ Unemployed ◻ Disabled
Occupational Exposures: ◻ Chemicals ◻ Sounds ◻ Overuse Injury ◻ Stress ◻ Other: _____

Occupation: _____ Dates: Start:_____ to _____
Living Condition: ◻ Home ◻ Nursing Home ◻ Home Health Care ◻ College ◻ Lives Alone ◻ With Spouse / Significant Other
◻ Assisted Living ◻ Homeless ◻ Other: _____
Health Equipment Use: ◻ Oxygen ◻ CPAP ◻ BiPAP ◻ Nebulizer ◻ Wheelchair ◻ Walker ◻ Wheeled Walker ◻ Cane
◻ Shower Chair ◻ Bedside Commode ◻ TENS Unit
Patient from Multiple Birth: ◻ Yes ◻ No Birth Order: _____
Number of children: _____ Grandchildren: _____
Social Activities: ◻ Volunteer Work ◻ Religious Group(s) ◻ Sports ◻ Social Group(s)
Education: ◻ None ◻ Elementary ◻ Some High School ◻ High School ◻ Some College ◻ College ◻ Graduate

Sexual History:
Are you sexually active: ◻ Yes ◻ No
Sexual Orientation: ◻ Straight or Heterosexual ◻ Lesbian, Gay, or Homosexual ◻ Bisexual ◻ Doesn't Know ◻ Chooses Not to Disclose
◻ Other: _____
History of unsafe sexual activity: ◻ Yes ◻ No
Gender Identity: ◻ Identifies as Male ◻ Identifies as female ◻ Female to Male (FTM)/Transgender Male / Trans Man◻
◻ Male-to Female (MTF)/Transgender/Female/Trans Woman ◻ Genderqueer, neither exclusively Male of Female
◻ Chooses Not to Disclose ◻ Additional Gender, Specify: _____

Travel:
Traveled Outside of Country: ◻ Yes ◻ No
Extended time sitting during travel: ◻ Yes ◻ No

Please check all that apply

Allergic / Immunologic
◻ Frequent Sneezing
◻ Hives
◻ Itching
◻ Runny Nose
◻ Sinus Pressure

Cardiovascular
◻ Arm Pain on Exertion
◻ Chest Pain on Exertion
◻ Chest Heaviness / Pressure on Exertion
◻ Irregular Heartbeats (Palpitations)
◻ Known Heart Murmur
◻ Light Headed on Standing
◻ Shortness of Breath when Walking
◻ Swelling (Edema)

Constitutional
◻ Exercise Intolerance
◻ Fatigue
◻ Fever
◻ Weight Gain (_____ lbs.)
◻ Weight Loss (_____ lbs.)

Eyes
◻ Dry Eyes
◻ Irritation
◻ Vision Change
Date of Last Exam: _____

Ears/Nose/Mouth/Throat
◻ Bleeding Gums
◻ Difficulty Hearing
◻ Dizziness
◻ Dry Mouth
◻ Ear Pain
◻ Frequent Infections
◻ Frequent Nosebleeds
◻ Hoarseness
◻ Mouth Breathing
◻ Mouth Ulcers
◻ Nose/Sinus Problems
◻ Ringing in Ears

Endocrine
◻ Fatigue
◻ Increased Thirst/Hunger/ Urination

Gastrointestinal
◻ Abdominal pain
◻ Black or Tarry Stool
◻ Blood in Stool
◻ Change in Appetite
◻ Frequent Indigestion
◻ Hemorrhoids
◻ Trouble Swallowing
◻ Vomiting
◻ Vomiting Blood

Genitourinary
◻ Blood in Urine
◻ Difficulty Urination
◻ Incomplete Emptying
◻ Increased Urinary Frequency
◻ Urinary Loss of Control

Hematologic/Lymphatic
◻ Easy Bruising/Bleeding
◻ Swollen Glands

Integumentary (Skin)
◻ Changes in Moles
◻ Dry Skin
◻ Eczema
◻ Growth/Lesions
◻ Itching
◻ Jaundice (Yellow Skin/Eyes)
◻ Rash

Musculoskeletal
◻ Back Pain
◻ Joint Pain
◻ Muscles Aches
◻ Muscles Weakness

Neurological
◻ Dizziness
◻ Fainting
◻ Headaches
◻ Memory Loss
◻ Migraines
◻ Numbness
◻ Restless Legs
◻ Seizures
◻ Weakness

Psychiatric
◻ Alcohol Overuse
◻ Anxiety/Stress
◻ Depression
◻ Do not reel safe in Relationship
◻ Mania
◻ Sleep Problems

Respiratory
◻ Cough
◻ Coughing up Blood
◻ Shortness of Breath
◻ Sleep Apnea
◻ Snoring
◻ Wheezing

Please add any other information about your health that you would like your providers to know here:

_____ _____
Patient, Parent, Guardian, or Caregiver Date:

_____ _____
Print Name Date of Birth