HEALTH HISTORY

Patient Label

TENNESSEE DEPARTMENT OF HEALTH

Person Completing form: ☐ **Patient** ☐ **Other** _____ **(specify relationship to client)**

GENERAL HEALTH/SAFETY QUESTIONS ABOUT PATIENT (Please answer all that apply)

Primary language of family members/guardian: ❑ English ❑ Spanish ❑ Other (specify):

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced Highest Grade Completed:

❑ Public Water Supply ❑ Other Water Supply ❑ Guns in the home ❑ Physical/Sexual abuse

❑ Wear seat belt/car seat ❑ Smoke detectors in home ❑ Regular Exercise ❑ Your mother took hormones (DES) while pregnant with you

TOBACCO USE

❑ Smoke Cigarettes — How many a day: _____

❑ Past Smoker — Date stopped: _____

❑ Chew/Dip — How frequently: _____

❑ Past Chew/Dip — Date stopped: _____

❑ Exposure to 2nd hand smoke — Where (car, house) _____

SUBSTANCE USE

❑ Alcohol — How much, how often _____

❑ Drugs (Street/IV) — How much, how often _____

VACCINE HISTORY

Last Tetanus: _____

Flu Vaccine: _____

Pneumo Vac: _____

MMR: _____

Hepatitis B _____

ADVANCE DIRECTIVES FOR HEALTH CARE (AGE 18 AND ABOVE ONLY)

Have you finalized any advance health directives? (examples–living will, durable power of attorney, organ donation, "do not resuscitate" instructions)

☐ YES ☐ NO If not, would you like information? ☐ YES ☐ NO Information Given ☐ YES ☐ NO

FOR CHILDREN UNDER 6 YEARS OF AGE ONLY

Birth Weight	Birth Length	☐ Vaginal Birth	☐ C-Section	☐ Premature Birth (less than 36 weeks)
☐ Pregnancy Complications:			☐ Delivery Complications:	
☐ Mother's Number of Prenatal Visits:		☐ Hospital Newborn Metabolic Screening		☐ Hospital Newborn Hearing Screening
Hospital of Birth:				Length of Hospital Stay:
Attends Day Care (Name):				

FAMILY MEDICAL HISTORY OF PATIENT (Please check appropriate box of family member for all that apply)

ARE YOU ADOPTED? ☐ YES ☐ NO ☐ UNKNOWN

	Father	Mother	Father's Parents	Mother's Parents	Brother Sister		Father	Mother	Father's Parents	Mother's Parents	Brother Sister
Anemia						Kidney Disease					
Cancer (specify type)						Glaucoma					
Diabetes						Bleeding Disorder					
Heart Disease/Attack						Sickle Cell Trait					
High Cholesterol						Mental Illness					
Stroke						Epilepsy/Seizures					
High Blood Pressure						Birth Defects					
Lung Disease						Other					

MEDICAL HISTORY OF PATIENT (Please check all that apply)

- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Birth Defect
- ❑ Blood disorder
- ❑ Blood clot
- ❑ Bowel/Stomach Problems
- ❑ Breast Disease
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Depression
- ❑ Diabetes
- ❑ Eating Disorder
- ❑ Epilepsy/Seizures
- ❑ Fainting
- ❑ Gallbladder Disease
- ❑ Hearing Impaired
- ❑ Heart Disease/Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV/AIDS
- ❑ Kidney/Bladder Disease
- ❑ Liver Disease/Hepatitis
- ❑ Lung Disease/Tuberculosis
- ❑ Measles
- ❑ Mental Health Problems
- ❑ Migraine Headaches
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Physical Activity Limitations
- ❑ Sexual Problems
- ❑ Sexual Transmitted Disease
- ❑ Sickle Cell Disease/Trait
- ❑ Skin Disorder
- ❑ Stroke
- ❑ Suicidal Thoughts
- ❑ Thyroid Disease/Goiter
- ❑ Ulcers
- ❑ Varicose Veins
- ❑ Vision Problems:
- ❑ Wears Glasses or Contacts

Most recent mammogram: Most recent colonoscopy:

❑ Other (list):

SURGERIES	DATE	HOSPITALIZATIONS/INJURIES	DATE

MEDICAL HISTORY CONTINUED			
Reproductive Health Questions	**Answer**	**Reproductive Health Questions**	**Answer**
Age at time of first period		*Have you had problems with any methods?	
Do you have a period every month?		How many times have you been pregnant?	
Average number of days menstrual bleeding		How many pregnancies resulted in a live birth?	
Is your bleeding heavy, medium, or light?		How many pregnancies ended in miscarriage?	
Do you have cramps with your period?		How many pregnancies ended in stillbirth?	
What medicine do you take for cramps?		How many pregnancies ended in abortion?	
*Have you ever had sex?		How many cesarean births have you had?	
*How old were you the first time you had sex?		Did you have any problems during a pregnancy?	
*How many sex partners have you had?		When was your last delivery?	
*How many sex partners have you had in the past 6 months?		Did you have a check up after your last delivery?	
*Does your sex partner use IV street drugs?		Are you breastfeeding?	
*Does your sex partner have sex with other women?		What was the birth weight of your smallest baby?	
*Does your sex partner have sex with men?		What was the birth weight of your largest baby?	
*Has your sex partner ever been in prison?		*Have you ever had an STD?	
*Has your partner(s) ever had an STD?		*Have you ever been diagnosed with HIV/AIDS?	
*Has your partner(s) ever had HIV?		*Have you ever had an AIDS test?	
*Have you ever experienced sexual or physical abuse?		When was your last Pap smear done?	
When, if ever, would you like to be pregnant?		Was your last Pap smear normal?	
*How many children would you like to have?		Have you ever had an abnormal Pap smear?	
*How do you prevent pregnancy now?		If you've had an abnormal Pap, when was that?	
*What method of birth control do you want today?			
*What other methods of birth control have you tried?			

Initial History reviewed with the client by:

STAFF SIGNATURE/TITLE _____ **DATE**_____

DO NOT WRITE BELOW THIS LINE - FOR STAFF USE ONLY

At top of column, put date of counseling. Then sign your initials across from the topic under the date column. Ideally, cover no more than 3-4 topics per visit. Cover different required topics each visit until all required topics and other topics are reviewed. Repeat only as needed.

Family Planning Required Topics	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Family involvement/Teens/1st visit						
Sexual coercion/Teens/1st visit						
Health dept. services & clinic routine						
Why test or screen?						
Tests and exam results						
All FP methods/abstinence/ECPs						
Informed consent/details of method						
24-Hour Emergency Care						
Reproductive health plan/spacing						
STDs & STD prevention/HIV testing						
Breast (♀)/Testicular (♂) self-exam						
Referral counseling done as needed						
Other Topics						
Nutrition/weight/folic acid/calcium						
High risk sexual & lifestyle behaviors						
ETOH, drugs, smoking cessation						
Domestic violence/personal safety						
ABCs of HIV Prevention						
♂ & ♀ anatomy and physiology						
Immunizations						
Pregnancy test results w/ counseling						
Bicycle, car/seatbelt & firearm safety						