PRAIRIE LAKES
Brown Clinic

HEALTH HISTORY PROFILE

Name: First _____ Middle _____ Last _____

Today's Date: _____ Date of Birth: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Best way to contact: ❑ Home ❑ Cell ❑ Work ❑ Email

Best time to contact: ❑ AM ❑ Afternoon ❑ PM

FILLING OUT THE FORM

Answering these questions will help your doctor understand your health and how best to treat you.

GENERAL HEALTH

1. Why did you make this appointment? (Check all the apply)
   - ❑ Regular Checkup
   - ❑ First appointment to start care with a new doctor
   - ❑ Switching doctors (from whom): _____
   - ❑ Have a specific health problem (please explain): _____
     _____

2. In general, what do you consider to be your main health problem(s)? (Check all the apply)
   - ❑ Heart Problems
   - ❑ Stomach Problems
   - ❑ Ear, Nose, or Throat Problems
   - ❑ High Blood Pressure
   - ❑ Diabetes
   - ❑ Depression / Emotional Problems
   - ❑ Joint Problems
   - ❑ Other (please explain): _____

3. How would you describe your health?
   ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor

4. Are you taking any prescription medications?
   ❑ YES. Please list your medications below and bring pill bottles with you to your appointment.
   ❑ NO. I don't take any prescription medications. (If no, go to questions 5)

Name of Medicine	Amount / Size of Pill	How many pills or doses do you take at:			
Flurosemide EXAMPLE	20mg	2 Morning	Noon	2 Dinner	Bed
		Morning	Noon	Dinner	Bed
		Morning	Noon	Dinner	Bed
		Morning	Noon	Dinner	Bed
		Morning	Noon	Dinner	Bed
		Morning	Noon	Dinner	Bed
		Morning	Noon	Dinner	Bed

Please use the back of this form if you have more prescription medications.

5. What over-the-counter medications, do you take regularly?
   ❑ Pain Reliever (Example: Tylenol, Advil, Motrin, Aleve, Asprin)
   ❑ Vitamins
   ❑ Antacid (Example: Tums, Prilosec)
   ❑ Herbal Medicine (Please list): _____
   ❑ Other (Please list): _____
   ❑ None - I do not take any over-the-counter medications regularly.

6. Have you ever had any allergic reaction (bad effects) to a medicine or a shot?
   ❑ YES. Please list the name of the medication and the effect you had.
   ❑ NO. I am not allergic to any medications.

Medicine I am allergic to	What happens when I take it
Atenolol EXAMPLE	I get a rash

7. Do you get an allergic reaction (bad effect) from any of the following? (check all the apply)
   ❑ Latex (rubber gloves)
   ❑ Grass or Pollen
   ❑ Eggs
   ❑ Shellfish
   ❑ Other _____
   ❑ No - I have no allergies that I am aware of.

8. Have you ever been a patient in a hospital overnight?
   ❑ YES. If yes, explain EACH reason and when.
   ❑ NO. I have never been a patient in a hospital.

Surgeries/hospitalization or inpatient treatment and reason	Date

9. Have you ever had a colonoscopy or Cologuard screening (a test to look at your insides by sending a camera through your bottom)?
   ❑ No ❑ Yes When? _____

10. Have you ever had a blood transfusion (when you are given extra blood)?
    ❑ No ❑ Yes When? _____

For Women Only

11. Have you had a DEX/Bone Density Test?
    ❑ No ❑ Yes Date of last one? _____

12. Have you had a PAP smear?
    ❑ No ❑ Yes Date of last one? _____

13. Have you ever had a PAP smear that was NOT normal?
    ❑ No ❑ Yes When? _____

14. Have you had a mammogram (breast x-ray)?
    ❑ No ❑ Yes Date of last one? _____

SHOTS

15. When was your last Tetanus shot? Year _____ ❑ Never ❑ Don't know

16. When was your last Pneumonia shot? Year _____ ❑ Never ❑ Don't know

17. When was your last Flu shot? Year _____ ❑ Never ❑ Don't know

SOCIAL HISTORY

18. Enter the highest grade you finished in school?
    Grade School: ❑ 1 ❑ 2 ❑ 3 ❑ 4 Middle School: ❑ 5 ❑ 6 ❑ 7 ❑ 8
    High School: ❑ 9 ❑ 10 ❑ 11 ❑ 12 GED: ❑
    Vocational School: ❑ 1 ❑ 2 ❑ 3 College: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ +

19. What language do you prefer to speak? ❑ English ❑ Spanish ❑ Other

20. How well can you read? ❑ Very Well ❑ Well ❑ Not Well ❑ I cannot read

21. What do you do during the day?
    - ❑ Work full-time - Occupation: _____
    - ❑ Work part-time
    - ❑ Attend School
    - ❑ Take care of children at home
    - ❑ Go out most days (shop, visit, appointments)
    - ❑ Stay home most days
    - ❑ Other _____

22. Have you ever smoked cigarettes, c-cigs, used a vaping device, pipe, cigars, used snuff, or chewed tobacco?
    - ❑ No (if no, go to question 23)
    - ❑ Yes

ARE YOU A:

- ❑ Current smoker
- ❑ Former smoker
- ❑ Non-smoker
- ❑ Current every day smoker
- ❑ Current some day smoker
- ❑ Smoker, current status unknown
- ❑ Unknown if ever smoked
- ❑ Light tobacco smoker
- ❑ Heavy tobacco smoker
- ❑ Uses tobacco in other forms

a. If current smoker": When did you start smoking? _____
b. If "current smoker": How often do you smoke cigarettes? _____
    - ❑ Every day
    - ❑ Some days, but not every day

c. If "current smoker": How many cigarettes a day do you smoke?
    - ❑ 5 or less
    - ❑ 6-10
    - ❑ 11-20
    - ❑ 21-30
    - ❑ 31 or more

d. If "current smoker": How soon after you wake up do you smoke your first cigarette?
    - ❑ Within 5 minutes
    - ❑ 6-30 minutes
    - ❑ 31-60 minutes
    - ❑ After 60 minutes

e. If "current smoker": Are you interested in quitting?
    - ❑ Ready to quit
    - ❑ Thinking about quitting
    - ❑ Not ready to quit

ADDITIONAL FINDINGS: Tobacco User

- ❑ Chain smoker
- ❑ Chews fine cut tobacco
- ❑ Chews loose leaf tobacco
- ❑ Chews plug tobacco
- ❑ Chews twist tobacco
- ❑ Heavy cigarette smoker (20-39 cigarettes/day)
- ❑ Light cigarette smoker (1-9 cigarettes/day)
- ❑ Moderate cigarette smoker (10-19 cigarettes/day)
- ❑ Pipe smoker
- ❑ Rolls own cigarettes
- ❑ Snuff user
- ❑ Trivial cigarette smoker (less than one cigarette/day)
- ❑ User of moist powdered tobacco
- ❑ Very heavy cigarette smoker (40+ cigarettes/day)

ADDITIONAL FINDINGS: Tobacco Non-User

- ❑ Aggressive non-smoker
- ❑ Current non-smoker
- ❑ Current non-smoker, but past smoking history unkown
- ❑ Does not use moist tobacco powdered tobacco
- ❑ Ex-cigar smoker
- ❑ Ex-cigarette smoker
- ❑ Ex-cigarette smoker amount unknown
- ❑ Ex-heavy cigarette smoker (20-30 cigarettes/day)
- ❑ Ex-light cigarette smoker (1-9 cigarettes/day)
- ❑ Ex-moderate cigarette smoker (10-19 cigarettes/day)
- ❑ Ex-pipe smoker
- ❑ Ex-trivial cigarette smoker (less than 1 cigarette/day)
- ❑ Ex-user of moist powdered tobacco
- ❑ Ex-heavy cigarette smoker (40+ cigarettes/day)
- ❑ Intolerant ex-smoker
- ❑ Intolerant non-smoker
- ❑ Never chewed tobacco
- ❑ Never used moist powdered tobacco
- ❑ Non-smoker for medical reasons
- ❑ Non-smoker for personal reasons
- ❑ Non-smoker for religious reasons
- ❑ Tolerant ex-smoker
- ❑ Tolerant non-smoker

ADDITIONAL FINDINGS: Tobacco User in Other Forms
(Brand Examples: NJOY, Blu, Vuse, JUUL, Sourin, JoyTech)

- ❑ E-cigs
- ❑ E-pipes
- ❑ E-liquid
- ❑ Pods
- ❑ Mods
- ❑ Vaporizers
    a. During the last 30 days, how many days did you use any of these products?_____

23. Do you drink alcohol?
    ❑ No (if no, go to question 24)
    ❑ Yes

Did you have a drink containing alcohol in the past year?
    ❑ Yes
    ❑ No
    a. If "Yes": How often did you have a drink containing alcohol in the past year?
        ❑ Never (0 points)
        ❑ Monthly or less (1 point)
        ❑ 2-4 times a month (2 points)
        ❑ 2-3 times a week (3 points)
        ❑ 4 or more times week (4 points)
    b. If "Yes": How many drinks did you have on a typical day when you were drinking in the past year?
        ❑ 1-2 drinks (0 points)
        ❑ 3-4 drinks (1 point)
        ❑ 5-6 drinks (2 points)
        ❑ 7-9 drinks (3 points)
        ❑ 10 or more drinks (4 points)
    c. If "Yes": How often did you have 6 or more drinks on one occasion in the past year?
        ❑ Never (0 points)
        ❑ Less than monthly (1 point)
        ❑ Monthly (2 points)
        ❑ Weekly (3 points)
        ❑ Daily or almost daily (4 points)

Interpretation
    ❑ Positive
    ❑ Negative

Interpretation - The AUDIT C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use).
    In men, a score of 4 or more is considered positive.
    In women, a score of 3 or more is considered positive.

24. Are you? ❑ Single ❑ Married ❑ Partnered ❑ Divorced or Separated ❑ Widowed

25. Who lives in your house?_____
    _____

26. Do you have any beliefs or practices from your religion, culture, or otherwise that your doctor should know? (for example)
    ❑ I am a Jehovah's Witness and do not accept blood/blood products.
    ❑ I do not use birth control because of personal/religious beliefs.
    ❑ I fast (go without for) for periods of time for personal or religious reasons.
    ❑ I am vegetarian (do not eat meat) ❑ I am vegan (do not eat anything that comes from animals)
    ❑ Other special diets or eating habits (please describe)_____
    ❑ Other beliefs _____
    ❑ No, I have no beliefs or practices that need to be included in my care.

27. Check any of the following thing you use to help you walk.
    ❑ Cane ❑ Walker ❑ Wheelchair
    ❑ Other_____
    ❑ I do not need help walking

28. Check any of the following types of help at home you receive (paid help or family and friends).
    ❑ Help with cleaning/laundry
    ❑ Help with shopping
    ❑ Help with personal care
    ❑ Help with taking my medications
    ❑ I do not use any help at home

29. In the past year, have you been emotionally or physically abused by your partner or someone important to you?
    ❑ Yes ❑ No

30. In the past year, have you been hit, pushed, shoved, kicked or threatened by a partner or someone important to you?
    ❑ Yes ❑ No

Exercise

Describe what kind of exercise you do. Check all that apply.	How many days per week do you exercise?	For how long do you exercise each day?
❑ Walking	❑ 1 time per week	❑ Less than 15 minutes
❑ Biking	❑ 2 times per week	❑ 15 - 30 minutes
❑ Swimming	❑ 3 times per week	❑ 30 - 45 minutes
❑ Weight Training	❑ 4 times per week	❑ 45 minutes - 1 hour
❑ Yoga	❑ 5 times per week	❑ Over 1 hour
❑ Other	❑ 6 times per week	
❑ I do not exercise	❑ 7 times per week	

Family History

Family Member	Medical Problem
Mother	❑ Diabetes (Sugar) ❑ High Blood Pressure ❑ Heart Problems ❑ Cancer ❑ Other _____
Father	❑ Diabetes (Sugar) ❑ High Blood Pressure ❑ Heart Problems ❑ Cancer ❑ Other _____
Sisters	❑ Diabetes (Sugar) ❑ High Blood Pressure ❑ Heart Problems ❑ Cancer ❑ Other _____
Brothers	❑ Diabetes (Sugar) ❑ High Blood Pressure ❑ Heart Problems ❑ Cancer ❑ Other _____

History of Medical Conditions

Have you ever had any of the following conditions? (check all that apply)

- ❑ Anemia (low blood iron)
- ❑ Asthma (wheezing)
- ❑ Diabetes (sugar)
- ❑ Heart Trouble
- ❑ Hemorrhoids (piles)
- ❑ Cancer
- ❑ Hepatitis (yellow jaundice)
- ❑ Tuberculosis (TB)
- ❑ Liver trouble
- ❑ Pneumonia
- ❑ Rhuematic fever
- ❑ Ulcers
- ❑ Stroke
- ❑ High blood pressure
- ❑ Skin problems
- ❑ Depression (feeling down/blue)
- ❑ Epilepsy (fits, seizures)
- ❑ Anxiety (nerves, panic attacks)
- ❑ VD, STD (Syphillis, Gonorrhea, Chlamydia, HIV)
- ❑ Other _____

Review of Systems

General	❑ Loss of appetite ❑ Weight gain ❑ Fatigue ❑ Weight loss ❑ Sweats ❑ Fever or chills ❑ Insomnia ❑ Mental fogginess
Eyes	❑ Eye discharge ❑ Blurred vision ❑ Glasses ❑ Vision loss ❑ Eye pain ❑ Double vision ❑ Contacts ❑ Eye itching/irritation
Ears, Nose, Throat	❑ Decreased hearing ❑ Hoarseness ❑ Ringing in ears ❑ Dental devices ❑ Pain swallowing ❑ Ear pain ❑ Nose bleeds ❑ Brush & floss daily
Cardiovascular	❑ Chest pain at rest ❑ Peripheral edema ❑ Chest pain with activity ❑ Palpitations
Respiratory	❑ Cough ❑ Shortness of breath ❑ Wheezing ❑ Palpitations
Gastrointestinal	❑ Abdominal pain ❑ Constipation ❑ Diarrhea ❑ Blood in vomit ❑ Reflux/Heartburn ❑ Vomiting ❑ Nausea ❑ Bloody or dark stool
Genitourinary	❑ Difficulty urination ❑ Painful urination ❑ Incontinence ❑ Blood in urine ❑ Frequent urination ❑ Change in urine color ❑ Increased night urination
Musculoskeletal	❑ Muscle twitching ❑ Muscle aches ❑ Back pain ❑ Joint swelling ❑ Muscle weakness ❑ Stress fractures ❑ Joint pain ❑ Broken bones
Skin	❑ Dry skin ❑ Acne ❑ Suspicious mole ❑ Itching ❑ Rash ❑ Unwanted hair growth
Neurological	❑ Dizziness ❑ Tremors ❑ Weakness ❑ Numbness
Psychiatric	❑ Depression ❑ Self harm behavior ❑ Anxiety ❑ Suicidal thoughts
Endocrine	❑ Cold intolerance ❑ Increased thirst ❑ Heat intolerance ❑ Weight change
Hematologic/Lymphatic	❑ Abnormal bruising ❑ Enlarged lymph nodes ❑ Easy bleeding

Emotional Health

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
Little interest or pleasure in doing things	❑	❑	❑	❑
Feeling down, depressed, or hopeless	❑	❑	❑	❑
Trouble falling or staying asleep, or sleeping too much	❑	❑	❑	❑
Feeling tired or having little energy	❑	❑	❑	❑
Poor appetite or overeating	❑	❑	❑	❑
Feeling bad about yourself or that you are a failure, or have let yourself or your family down	❑	❑	❑	❑
Trouble concentrating on things, such as reading the newspaper or watching television	❑	❑	❑	❑
Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	❑	❑	❑	❑
Thoughts that you would be better off dead or of hurting yourself in some way	❑	❑	❑	❑

Total Score: _____

Interpretation:

- ❑ Minimal Depression
- ❑ Mild Depression
- ❑ Moderate Depression
- ❑ Moderately Severe Depression
- ❑ Severe Depression

Interpretation of Total Score for Depression Severity

1 - 4 Minimal depression
5 - 9 Mild depression
10 - 14 Moderate depression
15 - 19 Moderately severe depression
20 - 27 Severe depression

Men Only:

- ❑ Urinary frequency at night
- ❑ Pain or burning with urination
- ❑ Blood in urine
- ❑ Discharge from penis
- ❑ Difficulty with erection or ejaculation
- ❑ Testicular pain or swelling

Women Only:

Age at onset of menstruation_____

Date of last menstruation _____

Average period occurs every _____ days and lasts_____ days

Heavy periods, irregularity, spotting, pain, or discharge ❑

Number of pregnancies _____ Number of live births_____

Are you pregnant or breastfeeding? ❑ No ❑ Yes

Have you had, D&C, hysterectomy, or cesarean? ❑ No ❑ Yes

Any urinary tract, bladder, or kidney infections within the last year? ❑ No ❑ Yes

Any blood in your urine? ❑ No ❑ Yes

Any problems with control of urination? ❑ No ❑ Yes

Any hot flashes or sweating at night? ❑ No ❑ Yes

Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ❑ No ❑ Yes

Experienced any recent breast tenderness, lumps, or nipple discharge? ❑ No ❑ Yes

Do you perform monthly self-breast examinations? ❑ No ❑ Yes