updated form 12-13-17

Health History Update

Please answer the following questions to assist Dr's Cook ,Calley Sr., Calley Jr., and Emily Luevanos, P.A. in providing more effective health care.

Circle **Yes** or **No** after each question. Place a "?" next to questions you do not understand or are unable to answer.

Thank You for completing this questionnaire.

DOB _____

All questions relate to the past 1 year

Name _____ **Age** _____ **Date** _____

Have You Had:			Physician Notes :
Weight loss ?	NO	YES	
Weight gain ?	NO	YES	
Fever or Chills ?	NO	YES	
Night sweats ?	NO	YES	
Swollen Glands or Lymph Nodes?	NO	YES	
Persistent Fatigue ?	NO	YES	
Feel Tired when You Wake Up?	NO	YES	
Feelings of Depression ?	NO	YES	
Feelings of Anxiety ?	NO	YES	
Trouble Falling or Staying Asleep?	NO	YES	
An HIV Blood Test ?	NO	YES	

Head, Eye, Ears, Nose, and Throat: **Have You Had:**			
Hay Fever ?	NO	YES	
Allergies ?	NO	YES	
Frequent Headaches ?	NO	YES	
Nose Bleeds ?	NO	YES	
Eye Pain ?	NO	YES	
Changes in Vision ?	NO	YES	
Difficulty Hearing ?	NO	YES	
Ear Pain ?	NO	YES	
Ringing in the Ears ?	NO	YES	
Hoarseness ?	NO	YES	
Mouth Sores or Dental Problems ?	NO	YES	
Dentures ?	NO	YES	
Throat Pain ?	NO	YES	
Sleep Apnea ?	NO	YES	
Do You Snore?	NO	YES	

Cardiopulmonary: **Have You Had:**			
Wheezing ?	NO	YES	
Shortness of Breath ?	NO	YES	
Frequent Coughing ?	NO	YES	
Chest Pain or Tightness ?	NO	YES	
Racing Heart or Palpitations ?	NO	YES	
Breathing Difficulty Lying Flat ?	NO	YES	
Coughing Productive of Blood ?	NO	YES	
Phlebitis or Blood Clots ?	NO	YES	
Frequent Leg Pain When Walking?	NO	YES	

Name_____ DOB_____

Breast (Men and Women)

New or Changing Breast Lumps?..... NO YES
Nipple Discharge?..... NO YES
Breast Pain ?..... NO YES
Skin Dimpling Over Breast?..... NO YES

Gastrointestinal Have You Had:

Heartburn or Indigestion ?..... NO YES
Abdominal Pain ?..... NO YES
Episodes of Nausea or Vomiting?..... NO YES
Difficulty Swallowing ?..... NO YES
Bowel Movements with Blood ? ..... NO YES
Black/Tarry Bowel Movements?..... NO YES
Hemorrhoids ?..... NO YES
Change in Bowel Movements ?..... NO YES
Constipation ?..... NO YES

Genito-Urinary Have You Had:

Frequent Urination ?..... NO YES
Uncomfortable/Painful Urination?..... NO YES
Difficulty Starting Urination ? ..... NO YES
Sexually Transmitted Disease ?..... NO YES
Genital Lesions ?..... NO YES
Uncontrolled Loss of Urine ? ..... NO YES
Pain with Intercourse ?..... NO YES
Blood in Urine ?..... NO YES

Skin Have You Had:

Rashes ?..... NO YES
Dry Skin ?..... NO YES
Changes in Moles ?..... NO YES
New Moles or Skin Markings ?..... NO YES

Musculoskeletal Have You Had:

Persistent Recurrent Back Pain?..... NO YES
Neck Pain ? ..... NO YES
Joint Pain ?..... NO YES
Joint Swelling ?..... NO YES
Recurrent Ankle Injuries ?..... NO YES
Shoulder Dislocations ?..... NO YES
Knee Injuries ?..... NO YES
Fractures ? ..... NO YES

Endocrine Have You Had:

Sweating ?..... NO YES
Increased Thirst ?..... NO YES
Libido Changes ?..... NO YES
Tremors ?..... NO YES

Name_____ DOB_____

Neurological: Have You Had:

Weakness in Arms or Legs ?	NO	YES
Numbness ?	NO	YES
Dizziness ?	NO	YES
Vertigo ?	NO	YES
Fainting (Syncope) ?	NO	YES
Episodes of Slurred Speech ?	NO	YES
Episodes of Facial Drooping ?	NO	YES
Convulsions or Seizures ?	NO	YES
Motor Changes ?	NO	YES
Sensory Changes ?	NO	YES
Kicking or Restless Legs at Night ?	NO	YES

Vascular: Have You Had:

General Edema ?	NO	YES
Change in Foot Size ?	NO	YES
Foot or ankle Swelling ?	NO	YES
Extremity Swelling Not Joint ?	NO	YES
Varicosities ?	NO	YES
Easy Bruising ?	NO	YES
History of Deep Vein Clot ?	NO	YES
A Family History of Clotting ?	NO	YES
Retinal Bleeding ?	NO	YES
A History of Aneurysm ?	NO	YES
History of a Stroke or TIA ?	NO	YES
Frequent Leg Pain When Walking ?	NO	YES

Hematology Have You Had:

Bleeding Gums?	NO	YES
Unexplained Bruising?	NO	YES
Family History of Clotting Disorder?	NO	YES

For Women Only Have You Had:

Changes in your Periods ?	NO	YES
Bleeding Between Periods ?	NO	YES
Cramping or Pain with Periods ?	NO	YES
Vaginal Discharge or Itch ?	NO	YES
Abnormal PAP Smear ?	NO	YES
Premenstrual Syndrome ?	NO	YES
Menopause Problems ?	NO	YES

For Men Only Have You Had:

Drip or Discharge from Penis ?	NO	YES
Rash on the Head or Shaft of Penis?	NO	YES
Lumps or Swelling at Testicles ?	NO	YES
Difficulty with Erections ?	NO	YES
Prostate Infections ?	NO	YES

Sexuality

Are you Sexually Active Now ?..... NO YES
Are you Generally Satisfied With Sex? .. NO YES
Are there Sexual Concerns you would like to discuss ? ..... NO YES
What do you do for Family Planning or Birth Control ? _____

_____

Work and Play (for all patients)

Are you Generally Satisfied with Work ?..... NO YES
Do you Exercise Regularly ? ..... NO YES
Kind of Exercise _____
Frequency _____
Hobbies or Leisure Activities _____

_____

_____

List the Foreign Countries you have been to in the Past 6 Months:

_____

_____

_____

_____

Preventive Health:

Have You Had:

			Date or Years Ago	With Who,Where
Colonoscopy in the Past ?..	NO	YES		
Mammogram Recently?.....	NO	YES		
Sleep Study ?.....	NO	YES		
Bone Density ?.....	NO	YES		
Eye Exam ?...if Diabetic Who.....	NO	YES		
Dental Examination ?.....	NO	YES		
Cardiac Exam ?.....	NO	YES		
Pap Test / Vaginal Exam ?..	NO	YES		
Smoking History ?.....	NO	YES		

Age Started	Packs/Day	# Of Years

Times /week	# of Drinks	# Of Years

Do you drink alcohol ? ..... NO YES

Do you have a risk of falling? NO YES
Are you unsteady walking?.. NO YES
Do you worry about falling?. NO YES
Did You fall last year?..... NO YES

Immunizations: Have You Had:

			Yrs ago of Date	Other Information
A Recent Tetanus Immunization ?.....	NO	YES		
Travel Immunizations ?.....	NO	YES		
Shingles Vaccine ?	NO	YES		
Pneumonia Vaccination ?.....	NO	YES		
Type of Pneumonia Vac ? Prevnar / Pneumovax				Prevnar / Pneumovax
Flu Immunizations in the Past ?.....	NO	YES		
Are You in Need of Immunizations ?..				
Type_____				

Risk Assessment:

Do you have a personal history of any of the following: Please (circle) positive responses:

Drug Use, Snuff, IV Drug use, Blood Transfusion, Multiple sexual partners, Homosexual sexual contact,

Sexual exposure to a person who has used IV Drugs, Bisexual sexual partners

Are you satisfied with the way your family :

Almost always	Some-times	Hardly ever	
_____	_____	_____	Helps you when you're in trouble.
_____	_____	_____	Shares and discusses your problems.
_____	_____	_____	Accepts and supports your new adventures.
_____	_____	_____	Gives affection and responds to your feelings.
_____	_____	_____	Shares time together.

Name_____ DOB_____

Social Support

88. Are you concerned about physical abuse in your family? . . . . . NO YES
89. Is your time well-balanced between work, family and leisure activities? . . . . . NO YES
90. Is your relationship with your friends as good as it was last Yr. . . . . NO YES
91. Is your relationship with your spouse as good as it was last yr. . . . . NO YES
92. Is there someone with whom you can always discuss your personal problems ? . . . . . NO YES
93. Would you like patient education materials ? . . . . . NO YES

Topics : _____

Heart Risk Factors

94. Male over 45. . . . . NO YES
95. Female over 55. . . . . NO YES
96. Diabetes . . . . . NO YES
97. Cigarette Smoking . . . . . NO YES
98. HDL Less than 40. . . . . NO YES
99. High Blood Pressure (>140/90). . . NO YES
100. 1st Degree relative with heart surgery or a heart attack, female age <65 or male age < 55. . . . . NO YES

Physician Notes :

Met Synd: # 3 of 5	Yes	No
Waist >40 in male->35 female		
Trig >150mg/dl		
HDL men <40 female <50		
BP >130/85		
Fasting glucose >110		

Special Information

Use the following lines to mention anything else about your health or social life that may be of concern. Include any important changes that have occurred either physically or emotionally.

Your Signature : _____

Physician's Signature : _____

Date : _____ M/D/Y