

# DENVER INDIAN HEALTH & FAMILY SERVICES

## HEALTH HISTORY

(Confidential)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

**SYMPTOMS** Check (x) symptoms you currently have or have had in the past year.

<p><b>GENERAL</b></p> <p><input type="checkbox"/> Chills  <input type="checkbox"/> Depression  <input type="checkbox"/> Dizziness  <input type="checkbox"/> Fainting  <input type="checkbox"/> Fever  <input type="checkbox"/> Forgetfulness  <input type="checkbox"/> Headache  <input type="checkbox"/> Loss of sleep  <input type="checkbox"/> Loss of weight  <input type="checkbox"/> Nervousness  <input type="checkbox"/> Numbness  <input type="checkbox"/> Sweats</p> <p><b>MUSCLE/JOINT/BONE</b>  Pain, weakness, numbness in:</p> <p><input type="checkbox"/> Arms    <input type="checkbox"/> Hips  <input type="checkbox"/> Back    <input type="checkbox"/> Legs  <input type="checkbox"/> Feet    <input type="checkbox"/> Neck  <input type="checkbox"/> Hands    <input type="checkbox"/> Shoulders</p> <p><b>GENITO - URINARY</b></p> <p><input type="checkbox"/> Blood in urine  <input type="checkbox"/> Frequent urination  <input type="checkbox"/> Lack of bladder control  <input type="checkbox"/> Painful urination</p>	<p><b>GASTROINTESTINAL</b></p> <p><input type="checkbox"/> Appetite poor  <input type="checkbox"/> Bloating  <input type="checkbox"/> Bowel changes  <input type="checkbox"/> Constipation  <input type="checkbox"/> Diarrhea  <input type="checkbox"/> Excessive hunger  <input type="checkbox"/> Excessive thirst  <input type="checkbox"/> Gas  <input type="checkbox"/> Hemorrhoids  <input type="checkbox"/> Indigestion  <input type="checkbox"/> Nausea  <input type="checkbox"/> Rectal Bleeding  <input type="checkbox"/> Stomach pain  <input type="checkbox"/> Vomiting  <input type="checkbox"/> Vomiting blood</p> <p><b>CARDIOVASCULAR</b></p> <p><input type="checkbox"/> Chest pain  <input type="checkbox"/> High blood pressure  <input type="checkbox"/> Irregular heart beat  <input type="checkbox"/> Low blood pressure  <input type="checkbox"/> Poor circulation  <input type="checkbox"/> Rapid heart beat  <input type="checkbox"/> Swelling of the ankles  <input type="checkbox"/> Varicose veins</p>	<p><b>EYE, EAR, NOSE, THROAT</b></p> <p><input type="checkbox"/> Bleeding gums  <input type="checkbox"/> Blurred vision  <input type="checkbox"/> Crossed eyes  <input type="checkbox"/> Difficulty swallowing  <input type="checkbox"/> Double vision  <input type="checkbox"/> Earache  <input type="checkbox"/> Ear discharge  <input type="checkbox"/> Hay fever  <input type="checkbox"/> Hoarseness  <input type="checkbox"/> Loss of hearing  <input type="checkbox"/> Nosebleeds  <input type="checkbox"/> Persistent cough  <input type="checkbox"/> Ringing in ears  <input type="checkbox"/> Sinus problems  <input type="checkbox"/> Vision - Flashes  <input type="checkbox"/> Vision - Halos</p> <p><b>SKIN</b></p> <p><input type="checkbox"/> Bruise easily  <input type="checkbox"/> Hives  <input type="checkbox"/> Itching  <input type="checkbox"/> Change in moles  <input type="checkbox"/> Rash  <input type="checkbox"/> Scars  <input type="checkbox"/> Sore that won't heal</p>	<p><b>MEN only</b></p> <p><input type="checkbox"/> Breast lump  <input type="checkbox"/> Erection difficulties  <input type="checkbox"/> Lump in testicles  <input type="checkbox"/> Penis discharge  <input type="checkbox"/> Sore on penis  <input type="checkbox"/> Other</p> <p><b>WOMEN only</b></p> <p><input type="checkbox"/> Abnormal Pap Smear  <input type="checkbox"/> Bleeding between periods  <input type="checkbox"/> Breast lump  <input type="checkbox"/> Extreme menstrual pain  <input type="checkbox"/> Hot flashes  <input type="checkbox"/> Nipple discharge  <input type="checkbox"/> Painful intercourse  <input type="checkbox"/> Vaginal discharge  <input type="checkbox"/> Other</p> <p>Date of last menstrual period? _____  Date of last Pap Smear? _____</p> <p>Have you had a mammogram? _____  Are you pregnant? _____  Number of children _____</p>
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**CONDITIONS** Check (x) conditions you have or have had in the past.

<p><input type="checkbox"/> AIDS  <input type="checkbox"/> Alcoholism  <input type="checkbox"/> Anemia  <input type="checkbox"/> Anorexia  <input type="checkbox"/> Appendicitis  <input type="checkbox"/> Arthritis  <input type="checkbox"/> Asthma  <input type="checkbox"/> Bleeding Disorders  <input type="checkbox"/> Breast Lump  <input type="checkbox"/> Bronchitis  <input type="checkbox"/> Bulimia  <input type="checkbox"/> Cancer  <input type="checkbox"/> Cataracts</p>	<p><input type="checkbox"/> Chemical Dependency  <input type="checkbox"/> Chicken Pox  <input type="checkbox"/> Diabetes  <input type="checkbox"/> Emphysema  <input type="checkbox"/> Epilepsy  <input type="checkbox"/> Glaucoma  <input type="checkbox"/> Goiter  <input type="checkbox"/> Gonorrhea  <input type="checkbox"/> Gout  <input type="checkbox"/> Heart Disease  <input type="checkbox"/> Hepatitis  <input type="checkbox"/> Hernia  <input type="checkbox"/> Herpes</p>	<p><input type="checkbox"/> High Cholesterol  <input type="checkbox"/> HIV Positive  <input type="checkbox"/> Kidney Disease  <input type="checkbox"/> Liver Disease  <input type="checkbox"/> Measles  <input type="checkbox"/> Migraine Headaches  <input type="checkbox"/> Miscarriage  <input type="checkbox"/> Mononucleosis  <input type="checkbox"/> Multiple Sclerosis  <input type="checkbox"/> Mumps  <input type="checkbox"/> Pacemaker  <input type="checkbox"/> Pneumonia  <input type="checkbox"/> Polio</p>	<p><input type="checkbox"/> Prostate Problem  <input type="checkbox"/> Psychiatric Care  <input type="checkbox"/> Rheumatic Fever  <input type="checkbox"/> Scarlet Fever  <input type="checkbox"/> Stroke  <input type="checkbox"/> Suicide Attempt  <input type="checkbox"/> Thyroid Problems  <input type="checkbox"/> Tonsillitis  <input type="checkbox"/> Tuberculosis  <input type="checkbox"/> Typhoid Fever  <input type="checkbox"/> Ulcers  <input type="checkbox"/> Vaginal Infections  <input type="checkbox"/> Venereal Disease</p>
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**MEDICATIONS** List all medications you are currently taking.

**ALLERGIES** To medications or substances


Pharmacy Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**(All information is strictly confidential)**

<b>FAMILY HISTORY</b> Fill in health information about your family						
Relation	Age	State of Health	Age at Death	Cause of Death	Check (x) if your blood relatives had any of the following	
					Disease	Relationship to You
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
Sisters					Heart Disease, Strokes	
					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

<b>HOSPITALIZATIONS</b>			<b>PREGNANCY HISTORY</b>		
Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Sex of Birth	Complications if any

**HEALTH HABITS:** Check (x) which substances you use & describe how much

Caffeine	
Tobacco	
Drugs	
Other	

**Have you ever had a blood transfusion?** \_\_\_ Yes \_\_\_ No  
If yes, please give approximate dates.

<b>SERIOUS ILLNESS/INJURIES</b>	<b>DATE</b>	<b>OUTCOME</b>

**OCCUPATIONAL CONCERNS:** check (x) if your work exposes you to the following:  
Stress  
Hazardous Substances  
Heavy Lifting  
Other

Your occupation: \_\_\_\_\_

**DO YOU HAVE ANY OTHER QUESTIONS OR CONCERNS THAT WE CAN ADDRESS?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_  
Date