

GREENBRIAR PRIMARY CARE HEALTH HISTORY SHEET

Last Name:	First Name:	Age:	Sex:	Doctor Notes do not write in this area			
Presenting Problem:							
Have you or any blood relative had the following							
	Self	Father	Mother		Sibling	Grandparent <small>Please specify</small>	Other <small>Please specify</small>
Allergic Rhinitis							
Anemia							
Anxiety							
Arthritis							
Asthma							
Atrial Fibrillation							
Depression							
Diabetes							
Emphysema							
Gout							
Headache							
Heart Attack							
Herniated Disc							
High Blood Pressure							
High Cholesterol							
Hypothyroid							
Insomnia							
Irritable Bowel Syndrome							
Migraine							
Heart Murmur							
Osteoporosis							
Skin Disorder							
Stroke							
Cancer							

Immunization	Year	Immunization	Year
Hepatitis A		Pneumococcus	
Hepatitis B		PPD	
Human Papilloma Virus (HPV)		Varicella	
Influenza (Flu Shot)		Zostavax	
Meningococcus		Tetanus	
Other		Childhood Vaccines up to date?	

SURGICAL HISTORY: Name of operation	Date	Complications

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Are you a smoker: Yes No Former Unknown

Number of packs/day:

Number of years:

Date you quit:

Number of packs/day before you quit:

Do you drink alcohol: Yes No Unknown

Type of alcohol: Beer Liquor Wine

Number of drinks: _____ per _____

Drug use: Yes No Unknown

Drug type:

Other habits:

ALLERGIES: Please list drug name and reaction				Doctor Notes <small>please do not write in this area</small>
Name of Drug/Item	Reaction	Name of Drug/Item	Reaction	
MEDICATIONS				
Name	Dose	How many times/day		

SOCIAL HISTORY Are you: Married Divorced Single Widowed Living with significant other	Do you have children? Yes No If yes, please list # and age(s)																						
SEXUAL HISTORY <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 20%;">Yes</th> <th style="width: 20%;">No</th> </tr> </thead> <tbody> <tr> <td>Are you sexually active?</td> <td> </td> <td> </td> </tr> <tr> <td>Is sex unsatisfactory in any way?</td> <td> </td> <td> </td> </tr> <tr> <td>History of Chlamydia?</td> <td> </td> <td> </td> </tr> <tr> <td>Gonorrhea?</td> <td> </td> <td> </td> </tr> <tr> <td>Venereal warts?</td> <td> </td> <td> </td> </tr> <tr> <td>Are you concerned about AIDS?</td> <td> </td> <td> </td> </tr> </tbody> </table>		Yes	No	Are you sexually active?			Is sex unsatisfactory in any way?			History of Chlamydia?			Gonorrhea?			Venereal warts?			Are you concerned about AIDS?			Sexual partners in past year: # of men: # of women: # unprotected:	
	Yes	No																					
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MAJOR ILLNESS OR INJURY: List any illness or injury requiring hospitalization. Include approximate date.

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OB/GYN HISTORY	Date or # if requested	Yes	No	Doctor Notes <small>do not write in this area</small>
Date of last menstrual period:				
Are your menses regular?				
# of days between periods				
# of days periods last				
Spotting between periods?				
Do you forget to do self breast exams monthly?				
Are you pregnant?				
# of pregnancies				
Date of last pregnancy				
# of live births				
# of abortions or miscarriages				
Date of last pap smear				
Was it abnormal?				
Have you ever had any other abnormal pap?				
Are you currently using contraception?				
Type of contraception				
Types of contraception used in past				
Over 1 year since last mammogram? If yes, date:				
Date of last bone density test (checks for osteoporosis)				

PERSONAL HABITS/RISK FACTORS				Doctor Notes <small>do not write in this area</small>
	Yes	No	Answers	
Do you ever not use seat belts?				
Number of hours of sleep/day				
Highest grade level achieved				
Do you exercise regularly?				
What exercise do you do?				
How often/week				
Do you have special stress in your life?				
Recent significant change in your life?				
What do you do to relieve stress?				
Any pets?				
Any hobbies?				
Occupation:				
Do you hate your job?				
Is your job a risk to your health?				
If yes (in any way), please explain:				
Date of last physical exam:				
Date of last colonoscopy:				
Date of last eye exam:				

- Reviewed by NP
- Scanned