Virginia Mason

Health History

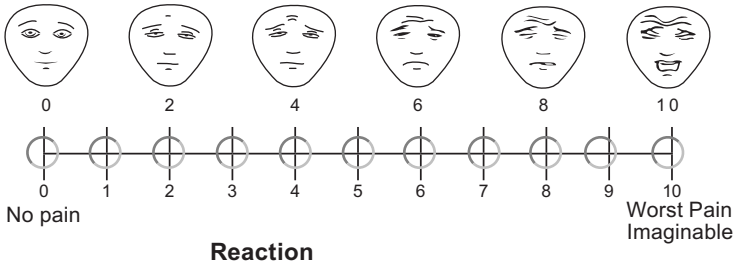
CONFIDENTIAL

Save form to your computer before completing it

Name:_____
Birthdate: _____
Today's Date: _____

Is this visit related to pain?

☐ No
☐ Yes, Select Pain Measurement Scale #:



Allergies

☐ **I have no known allergies**

I am allergic to:	**Reaction**

Yes	No	
☐	☐	I am allergic to latex
☐	☐	I am allergic to tape **(tape/glue)**
☐	☐	I am allergic to IV Contrast (X-ray Dye) **(Contrast Dye)**

Medications

Much of the information to complete below is on the label of your prescription bottles or can be obtained from your pharmacy or doctor's office. Be sure to include **ALL kinds of medications such as Vitamins, Herbal Medication, Supplements, Birth Control, Inhalers and Pain Relievers.**

☐ I take no Prescription Medications, Non-Prescription Medications or Other Medications.

Name of Medication	**Dosage**	**When do you take it?**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Social History

Alcohol Use: How many times in the past year have you had: Women: 4 or more drinks in a day? ____ Men under 65 years of age: 5 or more drinks in a day? ____ Men 65 years of age and older: 4 or more drinks in a day? ____	How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons? _____
Do you live with: ☐ Alone ☐ Sibling ☐ Child ☐ Significant other ☐ Father ☐ Spouse ☐ Mother ☐ Other	In the past 30 days, have you used tobacco? ☐Yes ☐No If Yes, are you interested in quitting? ☐Yes ☐No Number of cigarettes per day ____ Number of Years ____ Are you a former smoker? ☐Yes ☐No If Yes, at what age did you quit? ____ Number of cigarettes per day ____ Number of Years ____

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Today's Date: 0

FAMILY HISTORY

Please provide your **FAMILY's** health history below by checking the boxes for mother and/or father, and/or specifying other relatives (maternal or paternal grandfather, for example) on the line provided. Family includes mother, father, brothers, sisters, aunt, uncle, children and grandparents. You will be asked to provide **your own health history on the next page**

Mother	Father	Other Relative	Cancer
☐	☐	_____	Breast Cancer
☐	☐	_____	Colon Cancer
☐	☐	_____	Colonic polyp
☐	☐	_____	Leukemia
☐	☐	_____	Lung cancer
☐	☐	_____	Lymphoma
☐	☐	_____	Malignant melanoma
☐	☐	_____	Ovarian Cancer
☐	☐	_____	Pancreatic Cancer
☐	☐	_____	Skin Cancer
☐	☐	_____	Thyroid Cancer
☐	☐	_____	Prostate Cancer
☐	☐	_____	Uterine Cancer

Mother	Father	Other Relative	Cardiovascular
☐	☐	_____	Aortic aneurysm
☐	☐	_____	Bleeding disorder
☐	☐	_____	Blood clots
☐	☐	_____	Cerebral aneurysm
☐	☐	_____	Congestive Heart Failure
☐	☐	_____	Coronary Artery Disease
☐	☐	_____	Disorder of Heart Rhythm
☐	☐	_____	High Cholesterol
☐	☐	_____	Heart Attack
☐	☐	_____	High Blood Pressure
☐	☐	_____	Sudden Death

Mother	Father	Other Relative	Endocrine
☐	☐	_____	Diabetes mellitus
☐	☐	_____	Diabetes mellitus Type 1
☐	☐	_____	Diabetes mellitus Type 2
☐	☐	_____	Graves' Disease
☐	☐	_____	Hypothyroidism
☐	☐	_____	Thyroid disorder

Mother	Father	Other Relative	Eye
☐	☐	_____	Cataract
☐	☐	_____	Glaucoma
☐	☐	_____	Macular degeneration
☐	☐	_____	Partial Blindness
☐	☐	_____	Retinal detachment

Other Not Listed

☐	☐	_____	_____
☐	☐	_____	_____

Mother	Father	Other Relative	Gastrointestinal (GI)
☐	☐	_____	Colitis
☐	☐	_____	Crohn's disease
☐	☐	_____	GI Bleeding
☐	☐	_____	Pancreatitis
☐	☐	_____	Acid Reflux
☐	☐	_____	Ulcerative Colitis

Kidney

☐	☐	_____	Renal failure and on Dialysis
☐	☐	_____	Kidney Disease
☐	☐	_____	Kidney Stone
☐	☐	_____	Multi-cystic kidney

Neurologic

☐	☐	_____	Alzheimer's disease
☐	☐	_____	Developmental Delays
☐	☐	_____	Migraines
☐	☐	_____	Seizure
☐	☐	_____	Stroke

Ortho/Rheumatologic

☐	☐	_____	Arthritis
☐	☐	_____	Gout
☐	☐	_____	Osteoporosis
☐	☐	_____	Rheumatoid Arthritis
☐	☐	_____	Rheumatology Disorder

Psychiatric

☐	☐	_____	Alcoholism
☐	☐	_____	Bipolar Disorder
☐	☐	_____	Depression
☐	☐	_____	Drug Abuse
☐	☐	_____	Schizophrenia
☐	☐	_____	Suicide

Respiratory

☐	☐	_____	Allergies
☐	☐	_____	Asthma
☐	☐	_____	COPD
☐	☐	_____	Pulmonary Tuberculosis
☐	☐	_____	Sleep Apnea

☐ NONE ARE APPLICABLE TO MY FAMILY

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Today's Date: 0

PATIENT HEALTH HISTORY

Please complete this form to the best of your ability by checking any box that applies and including the approximate year of onset.

Cancer

	Year of Onset
☐ Bladder cancer	
☐ Breast cancer	
☐ Cervical cancer	
☐ Chemo-therapy	
☐ Colon cancer	
☐ Colon poyp	
☐ Leukemia	
☐ Lung cancer	
☐ Lymphoma	
☐ Ovarian cancer	
☐ Pancreatic cancer	
☐ Prostate cancer	
☐ Radiation therapy	
☐ Skin cancer: melanoma	
☐ Skin cancer: other	
☐ Thyroid cancer	
☐ Uterine cancer	

Cardiovascular

☐ Anemia	
☐ Aortic Aneurysm	
☐ Atrial Fibrillation	
☐ Bleeding disorder	
☐ Blood clots/DVT	
☐ Carotid artery blockage	
☐ Cerebral aneurysm	
☐ Congestive heart failure	
☐ Coronary artery disease	
☐ Disorder of heart rhythm	
☐ Heart valve problem-Aortic	
☐ Heart valve problem-Mitral	
☐ High blood pressure	
☐ High cholesterol	
☐ Peripheral artery disease	
☐ Stroke	
☐ TIA (Mini-stroke)	

Endocrine

Diabetes Type 1 ☐ Type 2 ☐	
☐ Graves' Disease	
☐ Hyperthyroidism	
☐ Hypothyroidism	
☐ Pre-diabetes/impaired fasting glucose	
☐ Thyroid nodule(s)	

Eye/Ear

☐ Amblyopia	
☐ Cataract	
☐ Glaucoma	
☐ Hearing loss	
☐ Macular degeneration	
☐ Strabismus	
☐ Partial Blindness	

Gynecology

☐ History of abnormal pap _____

Gastrointestinal (GI)

	Year of Onset
☐ Acid Reflux/heartburn	
☐ Cirrhosis of the liver	
☐ Crohn's disease	
☐ GI Bleeding	
☐ Irritable bowel syndrome	
☐ Pancreatitis	
☐ Ulcerative colitis	

Infections

☐ AIDS	
Hepatitis B ☐ or C ☐	
☐ HIV	
☐ MRSA(Resistant Staph)	
☐ Sexually Transmitted Disease	

Kidney

☐ Kidney Stone(s)	
☐ Renal insufficiency/failure	

Neurologic

☐ Alzheimer's Dementia	
☐ Dementia, not Alzheimer's	
☐ Learning Disability	
☐ Migraines	
☐ Multiple Sclerosis (MS)	
☐ Parkinson's	
☐ Seizure	

Orthopedic/Rheumatologic

Arthritis hip☐ knee☐	
☐ Gout	
Fracture hip☐ stress☐	
☐ Lupus	
☐ Osteoporosis	
☐ Rheumatoid arthritis	
☐ Scoliosis	

Other

☐ Psoriasis	
☐ Seasonal Allergies	

Psychiatric

☐ Anxiety disorder	
☐ Attention deficit disorder	
☐ Bipolar disorder	
☐ Depression	
☐ PTSD	
☐ Schizophrenia	

Respiratory

☐ Asthma	
☐ COPD	
☐ Pulmonary Tuberculosis	
☐ Sleep Apnea	

Other Not Listed

☐ _____ _____

☐ **I have *NONE* of the problems listed**

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Today's Date: _____

PATIENT SURGICAL HISTORY

Please indcate to the best of your ability, any surgical procedures you have by checking any box that apply. Please include the year in which the surgery occured.

Difficulty with IV insertion ☐ **Yes** ☐ **No** **(Provider to review)**

General/ Other	Year
☐ Appendectomy	_____
☐ Gall Bladder surgery	_____
☐ Hemorrhoids surgery	_____
☐ Left Kidney Removal	_____
☐ Right Kidney Removal	_____
☐ Mastectomy bilateral	_____
☐ Left Mastectomy	_____
☐ Right Mastectomy	_____
☐ Organ Transplant	_____
☐ Prostate TURP	_____
☐ Prostatectomy for Cancer	_____
☐ Left Thyroidectomy	_____
☐ Right Thyroidectomy	_____
☐ Tonsillectomy	_____
☐ Weight Loss Surgery	_____
Eye/Ear/Nose/Throat	_____
☐ Left Cataract removal	_____
☐ Right Cataract removal	_____
☐ Left Cochlear implant	_____
☐ Right Cochlear implant	_____
☐ Sinus surgery	_____
Gynecology	
☐ Bladder "lift" or sling	_____
☐ Lt Breast biopsy/cyst removal	_____
☐ Rt Breast biopsy/cyst removal	_____
☐ Left Breast reconstruction	_____
☐ Right Breast reconstruction	_____
☐ Cautery of cervix	_____
☐ Cesarean Section	_____
☐ Hysterectomy (cervix removed)	_____
☐ Hysterectomy (cervix not removed)	_____
☐ Left ovary removal	_____
☐ Right ovary removal	_____
☐ Tubal ligation/sterilization	_____
Anesthesia (for surgery)	
☐ Complications or reactions **(Provider to review)**	_____

Cardiovascular	Year
☐ Aneurysm repair	_____
☐ Coronary Angioplasty/Stent	_____
☐ Coronary artery bypass	_____
☐ Valve Replacement - Aortic	_____
☐ Valve Replacement - Mitral	_____
☐ Pacemaker or Defibrillator	_____
Orthopedic	
☐ Left carpal tunnel repair	_____
☐ Right carpal tunnel repair	_____
☐ Left Hip Replacement	_____
☐ Right Hip Replacement	_____
☐ Left Knee Arthroscopy	_____
☐ Right Knee Arthroscopy	_____
☐ Left Knee Replacement	_____
☐ Right Knee Replacement	_____
☐ Left Rotator Cuff repair	_____
☐ Right Rotator Cuff repair	_____
☐ Left Torn Ligament repair	_____
☐ Right Torn Ligament repair	_____
☐ Left Wrist Arthroscopy	_____
☐ Right Wrist Arthroscopy	_____
Neurologic	
☐ Laminectomy (Spine Surgery)	_____
Other Not Listed	
☐ _____	_____
☐ _____	_____

☐ **I have reviewed the above and have had *NONE* of the surgeries listed or added.**