District 4 Patient Self-History Form

Place patient label here.

Are you allergic to any foods or medications? ☐ Yes ☐ No

If yes, please list the name and reaction? ____

List all of the medications that you are currently taking (including birth control, herbs and over the counter medications):

____

Do you have a Primary Care Physician (PCP) or a place where you receive routine medical care? ☐ Yes ☐ No

Are you currently being treated for an illness? ☐ No ☐ Yes ____

Circle Y for "Yes" or N for "No." If you are unsure about any question, leave blank and ask the nurse for help. Family history includes your mother, father, grandparents on both sides, aunts, uncles, and brothers and sisters (only blood related).

Medical History: Circle those that apply, Y for yes or N for no	**YOU**	**FAMILY**	NURSING COMMENTS
Birth Defects	Y or N	Y or N	
Breast	Y or N	Y or N	
Cancer	Y or N	Y or N	
Communicable Disease (HIV/Measles/Varicella)	Y or N	Y or N	
Dermatologic (Acne/Eczema/Psoriasis)	Y or N	Y or N	
Ear/Nose/Throat/Mouth	Y or N	Y or N	
Gastrointestinal Disorders	Y or N	Y or N	
Genetic Disorders (Down's Syndrome/Sickle Cell)	Y or N	Y or N	
Genitourinary Disorders (Frequent UTIs, Ovarian Cysts, Uterine Fibroids, etc.)	Y or N	Y or N	
Hearing Problems	Y or N	Y or N	
Heart Disease (Hypertension/Stroke/Heart Attack/Murmur)	Y or N	Y or N	
Hematologic (Anemia/Blood Clots/Blood Transfusions)	Y or N	Y or N	
Hepatobiliary Disorders (Liver Disease/ Hepatitis/Gallbladder Disease/Pancreatitis)	Y or N	Y or N	
Hospitalizations/Emergency Room Visits/Surgeries	Y or N		
Infectious Disease	Y or N	Y or N	
Kidney Disease	Y or N	Y or N	
Lung Disease(Asthma/Chronic Bronchitis/COPD/Tuberculosis (TB))	Y or N	Y or N	
Metabolic/Endocrine (Diabetes/Thyroid Problems)	Y or N	Y or N	
Musculoskeletal (Arthritis/Gout/Osteoporosis)	Y or N	Y or N	
Neurologic (Seizures/Migraines)	Y or N	Y or N	
Overweight/Obesity	Y or N	Y or N	
Oral Cavity Disorders (Implants/Ulcers/Cavities)	Y or N	Y or N	
Psychological Disorders (Depression/Bipolar Disorder/Anxiety/Suicidal Thoughts)	Y or N	Y or N	
Reproductive (total # of pregnancies _____, # full-term _____, # premature ____, # stillborn _____, # of abortions _____, # of miscarriages ________	Y or N		
Rheumatological (Lupus/Rheumatoid Arthritis)	Y or N	Y or N	
Sexually Transmitted Diseases (STDs)	Y or N		
Vision Problems (Cataracts/Glaucoma/Glasses/Contacts)	Y or N	Y or N	

Georgia Department of Public Health
District 4 Public Health

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Do you drink alcohol? Y or N If yes, what type? ________ Amount: __________ Frequency: _____________________	Have you ever been hit, kicked, shoved or had things thrown at you by your partner? Y or N
Do you use drugs? Y or N If yes, what type? ________ Amount: __________ Frequency: _____________________	Have you ever been forced by anyone to have intercourse or any form of sexual contact against your will? (when you have said or wanted to say no) Y or N
What was the last grade you completed in school? __________	Have you or your children ever been afraid / threatened by your partner / boyfriend? Y or N
Do you work? (circle one) Full-time Part-time Unemployed Student Other _____ Occupation: ____________________________________	What is your marital status? (circle one) Divorced Living with Partner Married Single Widowed
Have you ever been incarcerated (jail or prison)? Y or N	Do you ever feel like hurting yourself? Y or N
Are you currently on parole? Y or N	Have you ever used a needle to inject drugs? Y or N
Who do you live with? _________________________________	Have you ever exchanged sex for drugs or money? Y or N
Do you smoke, chew or dip tobacco? Y or N If yes, how much per day? _________________________	Have you ever had sex while using non-injected drugs? Y or N
Have you ever smoked tobacco and quit? Y or N	

Men and Women:

Age at first intercourse? _______________________________
Date of last intercourse: _______________________________
# of partners in the last year? _________________
Any new partners in the last 60 days? □ Yes □ No
# of partners in last 60 days? _________
Do you use condoms every time that you have sex? Y or N
Do you have sex with?
□ Men only □Women only □ Both Men and Women
Last HIV test date: ________ Last HIV result: _____________
Does your partner(s) have any problems? □ Yes □ No
Check all the ways you have sex: □ Vaginal □ Oral □ Anal
What do you use for birth control? (check all that apply)
□Male Condoms □Female Condoms □Diaphragm □Pills
□Foam/Gel □Patch □Depo □Implant □IUD □Abstain
□Tubal ligation □Vasectomy □Withdrawal/Pull Out
□None □Other __________________________________
Are you satisfied with the method? □ Yes □ No
If no, which method(s) do you wish? ____________________
Do you or your partner want to become pregnant? Y or N
If yes, when? __________________________________
What is your present health status?
□ Excellent □ Good □ Fair □ Poor
Have you received dental care in the past year? □ Yes □ No

Women only:

What age did your menstrual periods begin? _______________
When did your last period start? ________________________
How many days did it last? ____________________________
Was it normal? □ Yes □ No Explain _____________________
Any period problems? __________________________________
Painful periods that require medication? __________________
Do you douche? □ Yes □ No
Do you have vaginal discharge or odor? □ Yes □ No
Do you examine your breasts? Y or N How often? __________
Any breast problems? __________________________________
Date of your last pelvic exam: ___________________________
Date of your last pap smear: ____________________________
Have you ever had an abnormal pap smear? □ Yes □ No
Have you ever had a mammogram? □ Yes □ No
Date of your last mammogram: __________________________
Date of your last colorectal screening test: ________________
Date your last pregnancy ended: _________________________
Are you breast feeding now? □ Yes □ No
Did your mother take DES (diethylstilbestrol) when she was pregnant with you (if born before 1972)? Y or N
Did you have any problems with any pregnancies? Y or N

Men only:

Have you been circumcised? Y or N
Do you have any problems with testicles or scrotum (lumps, pain, swelling)? Y or N
Do you perform testicular self-exams? Y or N
Have you ever been involved in a pregnancy or fathered a child? Y or N