Health History

Wamego Family Clinic
BETTER HEALTH. BETTER COMMUNITY.

Patient Name:		Male/Female:
Birth Date:	Race/Ethnicity:	Language:

Address: Phone: Alternate Phone:

Ongoing Medical Problems: (List additional on back) Does Not Apply ◇

1 2 3

4 5 6

Allergies: (Medications, food, and other) Does Not Apply ◇

Current Medications: (List additional on back) Does Not Apply ◇

Name	Strength	Frequency	Name	Strength	Frequency
1			5		
2			6		
3			7		
4			8		

Surgeries/Date: (List additional on back) Does Not Apply ◇

1 2 3

Hospitalizations/Date: (Within last 2 years-List additional on back) Does Not Apply ◇

1 2 3

Date of Last Colonoscopy: Results: Does Not Apply ◇

Date of Last Echocardiogram: Results: Does Not Apply ◇

Date of Last Cardiac Stress Test: Results: Does Not Apply ◇

Men Only:	Yes/No	Explain
Swelling or tender testicles or scrotum:		
Vasectomy:		Vasectomy Date:
Prostate Problems:		Last Prostate Exam:
PSA checked:		Date PSA Last Checked:
Other:		

Women Only:	Yes/No	Explain
Irregular Periods:		Last Period Date:
Abnormal Pap Smear:		Last Pap Smear Date:
Abnormal Mammogram:		Last Mammogram Date:
Dexa Scan: Date of Dexa Scan:		Last Dexa Scan Date:
Number of Pregnancies: Number/Type of Deliveries:		

Self and Family History: (Please indicate family relation to you and Mom and/or Dad side of the family)

	Self	Other Relations			Self	Other Relations	
Glaucoma			Mom/Dad	Ulcer			Mom/Dad
Asthma			Mom/Dad	Diabetes			Mom/Dad
COPD/Bronchitis			Mom/Dad	Thyroid Disorder			Mom/Dad
Emphysema			Mom/Dad	Arthritis			Mom/Dad
Heart Disease			Mom/Dad	Osteoporosis			Mom/Dad
High Blood Pressure			Mom/Dad	Migraines			Mom/Dad
DVT/Phlebitis (clots)			Mom/Dad	Rheumatic Fever			Mom/Dad
Pneumonia			Mom/Dad	Epilepsy			Mom/Dad
Stroke			Mom/Dad	Alcohol/Drug Addiction			Mom/Dad
Tuberculosis			Mom/Dad	STD			Mom/Dad
Anemia			Mom/Dad	Depression			Mom/Dad
Bleeding Problems			Mom/Dad	Anxiety			Mom/Dad
Celiac			Mom/Dad	Dementia			Mom/Dad
Colitis			Mom/Dad	Other Mental Health Conditions			Mom/Dad
Kidney/Bladder/ Urinary Tract Infections			Mom/Dad	Cancer			Mom/Dad
Liver Disease			Mom/Dad	Other:			Mom/Dad
Hepatitis			Mom/Dad				Mom/Dad

Home Medical Equipment Used:

Occupation:

Employed Full or Part Time: (Explain) _____

Retired ◇ Student ◇ Unemployed ◇ Disabled (Explain): ◇

Support System:

Marital Status: Who Lives With You?

Living Situation: Home ◇ Independent ◇ With Assistance ◇ Explain:

Nursing Home ◇ Hospice ◇ Other:

Social:	Yes/No	(Explain Type/Amount/Length of time/Attempts to quit)
Tobacco		
Alcohol		
Illicit Drugs		
Caffeine		
Exercise	Yes/No	(Explain Type/Frequency/Duration)

Immunizations:	Yes/No	Dates	Immunizations:	Yes/No	Dates
Tetanus (Td)			Hepatitis A		
With Pertussis (Tdap)			Hepatitis B		
Varicella-Chicken Pox			MMR		
Tb Test			Meningitis		
Pneumovax			Zostavax-Shingles		
Influenza-Flu shot			HPV		
Other:			Other:		

The above information is complete and accurate to the best of my knowledge:

Patient/Guardian Signature: _____ Relation: _____ Date: _____