KEARNEY COUNTY
HEALTH SERVICES
Minden Medical Clinic

Health Risk Assessment & History

Patient Name: ________________________________ Date: ________________________

Date of Birth: ________________________________ Home Phone: _________________

Cell Phone: ___________________

Who Is your Provider? ____

PAST HISTORY (Personal)

Have you had any of the following illnesses?

	YES	NO
Rheumatic Fever		
Angina Pectoris		
Heart Attack		
Heart Failure		
Heart Rhythm Problems		
Other Heart Disease		
High Cholesterol		
Sugar Diabetes		
High Blood Pressure		
Cancer		
Stroke, Epilepsy, or Seizures		
Migraine Headaches		
Depression, Anxiety, or a Nervous Condition or Disorder		
Parkinson's Disease		
Anemia or Blood Disease		
Blood clots form in the lung or leg		
Kidney Disease		
Frequent Kidney or Bladder Infections or Kidney Stones		
Prostate Problems		
Gout		
Hay Fever or Food Allergies		
Asthma		
Pneumonia or Bronchitis		
Emphysema		
Thyroid Disease		
Stomach Ulcers or Hiatal Hernia		
Gallbladder Disease		
Jaundice		
Hepatitis		
Pancreatitis		
Colitis		
Colon polyps, Tumors, or Diverticulosis		
Breast Disease		
Skin Disease or Cancer		
Arthritis		
Osteoporosis or Bone Disease		
Chicken Pox, Mumps, Measles, or Scarlet Fever		
Other Chronic Disease		

Please List: ________________________________

____

Operations and Biopsies (even simple ones like tonsillectomies, hernia, hemorrhoid repairs, or eye surgery)

Date	Procedure

Outpatient Surgeries or Procedures:

Date	Procedure

Hospitalizations (other than operations):

Date	Procedure

Serious Injuries such as broken bones or concussions.

Date	Procedure

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FAMILY HISTORY

	NAME	If Living		If Deceased	
		Age	Health	Age at Death	Cause
Father					
Mother					
Brothers / Sisters	Circle Sex				
	M F				
	M F				
	M F				
	M F				
	M F				
	M F				
Husband / Wife					
Sons / Daughters	Circle Sex				
	M F				
	M F				
	M F				
	M F				
	M F				

FAMILY HISORY

Check if any blood relative has or has had any of the following and enter relationship

	YES	NO	Relationship
Stroke			
High Blood Pressure			
Diabetes			
Cancer			
Leukemia			
Bleeding Tendency			
Kidney Disease			
Goiter			
Arthritis			
Gout			
Heart Attack			
Rheumatic Heart			
Congenital Heart defect			
Heart Rhythm problems			
High Cholesterol			

	YES	NO	Relationship
Pacemaker			
Loss of Consciousness			
Death without known cause			
Osteoporosis			
Stomach Ulcers			
Colitis			
Asthma			
Hay Fever			
Emphysema			
Tuberculosis			
Migraine			
Psychiatric problems			
Insanity			
Suicide			
Epilepsy			

Are there any diseases Inherited in your family? ____

____

SOCIAL HISTORY

	YES	NO
Did you complete high school education?		
Did you attend and/or complete college?		
Are you married?		
Have you ever been widowed or divorced?		
Do you have concerns with domestic violence?		

What is your present hometown? ______________________

How many people live in your household? ______________________

What is your occupation? ______________________

What is your spouse's occupation? ______________________

Do you attend or belong to a church? ______________________

If yes, what denomination? ______________________

Name: ______________________________________ Date of Birth: ______________________

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MEDICATIONS

Check which of the following, if any, you are regularly taking

__ Asthma or Wheezing medicine
__ Aspirin, Bufferin, Anacin
Tylenol, or similar products
__ Blood pressure pills
__ Cortisone, Prednisone
__ Digitalis or heart medicine
__ Hormones or birth control pill
__ Insulin or diabetic pills
__ Iron or poor blood medications
__ Laxatives
__ Sleeping pills or tranquillizers
__ Herbal/ Alternative medicine
__ Thyroid medicine
__ Stomach or Digestive medicine
__ Weight-reducing pills
__ Blood-thinners or Coumadin
__ Water pills, diuretics
__ Antibiotics
__ Phenobarbital or barbiturates
__ Vitamins
__ Recreational drugs
__ Other (list below)

Other Medications: ____
____
____

Please list other drugs or injections including over-the-counter pills: ____
____

Medication Present Dosage Date started medication

____
____
____
____

Have you had a bad reaction to any medications?
____ No ____ Yes (please specify below)

Date Procedure

_____ ____
_____ ____
_____ ____

Immunizations: Please give dates

Have you had your childhood immunizations? __ Yes __ No

Last Flu shot? ____

Last Pneumonia vaccination? ____________________________

Last Tetanus shot? _____________________________________

Last Shingles vaccine? _________________________________

Last HPV Vaccine? ____________________________________

Any other vaccines you have received: ____________________
____
____

PERSONAL HABITS

1. Do you use tobacco or did you ever use tobacco regularly?
___ No ___ Yes (please specify below)

In what forms:	YES	NO
Cigarettes	______	______
Cigars	______	______
Pipe	______	______
Chewing Tobacco	______	______

How old were you when you started smoking? _____________

How old were you when you quit smoking, if you have quit?
____

How many packs per day would you estimate you averaged over the years? ______________________________________

How many packs per day do you smoke now? _____________

2. What sort of alcohol do you drink?
None
Hard liquor __ 1-3 oz. per day __ Over 3 oz. per day
Beer __ 1 bottle per day __ 2 bottles __ 3 or more
Wine __ 1 glass per day __ 2 glasses __ 3 or more

3. Have you or do you use recreational street drugs?
Meth ____ Marijuana ____ Cocaine ____ Heroin ____
Other: ____
Have you ever been treated for a substance abuse problem?
____ No ____ Yes

4. Do you drink coffee, tea, or caffeinated soft drinks?
____ No ____ Yes
If yes, how much per day? ___________________________

5. Do you have difficulty sleeping?
______ Never ______ Often ______ Sometimes

6. Do you awaken very early in the morning without apparent cause and find it difficult to fall asleep again?
______ Frequently ______ Occasionally ______ Rarely

7. Do you have special food customs or restrictions such as low salt, sugar, or cholesterol? ____Yes ____ No
Do you follow any other type of specific diet? ______________
____

8. Do you exercise regularly? ____Yes ____ No
What type of exercise? ________________________________
How long? ______________ How often? _________________

9. Do you have any allergies? ____Yes ____ No
If so, please list: _____________________________________
____
____

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REVIEW OF SYSTEMS

A. General	YES	NO
Do you worry a lot about your health?		
Do you usually feel tired or worn out?		
Do you feel depressed a lot of the time?		
Have you recently noticed that heat or warm weather bothers you?		
Have you recently been drinking more water or fluids?		
Has there been any unusual weight gain or loss recently or change in your appetite?		
Have you had any unexpected fevers, chills, or night sweats?		
Have you had any swollen lymph glands?		
Have you had bleeding or bruising?		
Have you had any difficulty sleeping?		

B. Skin	YES	NO
Have you noticed:		
Any change in the color of your skin?		
Any skin rashes or Itching?		
Unusually dry skin?		
Any growth on your skin that bothers you?		
Any sores or wounds that do not heal?		
Any changes in the color or size of warts?		
Any changes in your hair?		
Do you use sunscreen on a regular basis?		
Do you have moderate sun or ultraviolet tanning exposure?		

C. Eyes	YES	NO
Have you had:		
Any pain in your eyes?		
Glaucoma or cataracts or other eye disease?		
Double vision or blurry vision?		
Sudden change in vision?		

When was your last eye exam by an eye care provider? ___ Last year ___ Last 2 years ___ Longer

D. ENT	YES	NO
Do you have:		
Any trouble hearing?		
Ringing or buzzing in your ears?		
Earaches or other discharge from your ears?		
A lot of nasal stuffiness?		
Drainage down the back of your throat?		
Frequent or severe nose bleeds?		
Persistent hoarseness		
A lump in your throat?		
A sore tongue or mouth?		
Bleeding gums?		
Dental problems?		

How long since your last visit to a dentist?
___ Last year ___ Last 2 years ___ Longer

E. Respiratory	YES	NO
Do you have:		
Frequent chest colds?		
A constant or bothersome cough?		
Coughing of blood?		
Sputum or phlegm between colds?		
Pain or difficulty breathing?		
Have you noted any wheezing or whistling in your chest?		
Tuberculosis, exposure to that disease or a positive skin test?		

F. Cardiovascular	YES	NO
Do you have pain, tightness, or pressure in the front or back of your chest?		
If yes, is it when walking fast, working hard, or when excited?		
Have you ever been told that your electrocardiogram was abnormal?		
Do you have swelling of your feet or ankles?		
Does your heart ever beat fast or irregularly?		
Do you have cramps in the calf muscles when you walk?		
Do you ever awaken in the night with severe difficulty breathing?		
Do your finger or toes ever throb or turn very pale or blue in the cold?		
Do you have trouble breathing when walking?		
Have you been tired?		
Have you had a heart murmur?		

G. Gastrointestinal	YES	NO
Have you recently had any change in your eating habits?		
Are there any special foods that cause you to have upset or stomach pains, nausea, etc., (For example: milk products)		
Do you belch or pass gas excessively?		
Have you recently noted trouble swallowing?		
Do you have a lot of indigestion or heartburn?		
Have you ever vomited blood?		
Are you bothered with constipation?		
Do you have frequent loose stools or diarrhea?		
Do you have a poor appetite?		
Do you ever awaken at night with the feeling of fullness underneath your breast bone?		
Have you ever passed blood from your rectum?		
Have you ever had black or tarry stools?		
Have you noticed any recent changes In your bowel movement such as constipation or diarrhea?		
Do you take laxatives or enemas regularly?		
Do you have frequent nausea and/or vomiting?		
Have you had a colonoscopy?		

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H. Genitourinary

	YES	NO
Do you have:		
Anything wrong with your genitals (privates)?		
Burning or pain when you urinate?		
To pass urine frequently?		
To pass more urine than you used to?		
Trouble passing urine; losing control?		
To get up at night to urinate?		
Trouble with losing urine when you cough or sneeze?		
A problem dribbling urine?		
Have you ever passed blood in your urine?		
Have you had an operation to prevent pregnancy? (vasectomy or sterilization, such as a tubal ligation)		
Do you have prostate gland trouble?		
History of sexually transmitted disease?		
New or unexplained problems with your sex life?		

I. Musculoskeletal

	YES	NO
Do you have a problem with back pain or pain in other bones?		
Do you have pain In your legs or feet?		
Does back pain interfere with your work or activities?		
Do you have joint pain or stiffness?		
Do you have trouble walking or using your hip or knee joints?		

J. Central Nervous System

	YES	NO
Do you have frequent or sever headaches?		
Do you often have spells of dizziness or faintness or light-headedness?		
Have you ever seen double?		
Do you sometimes lose track of what happens around you for a short time?		
Do you sometimes lose the ability to speak for a few seconds?		
Have you recently fainted, blacked out, or lost consciousness?		
Do you have trouble remembering events?		
Have you ever had convulsions or seizures?		
Do you have numbness or tingling in your head, arms, or legs, or sudden loss of strength in your arms or legs?		
Have you had a concussion, head, or neck Injury?		
Do you consider yourself a nervous person?		
Do you cry a lot for no reason?		
Have you had the urge to commit suicide?		
Do you ever hear voices or see people when no one Is around?		
Do you ever have the feeling that someone Is trying to harm you?		
Do you ever have abnormal movements or tremors of your arms or legs?		

K. Women Only

	YES	NO
Did your menstrual periods start before you were 10?		
Did your menstrual periods start after you were 15?		
Are your periods less frequent than every four weeks??		
Do you use more than 10 pads or have to use a super-sized pad or tampon for your periods?		
Do you pass clots with your periods?		
Do you become bloated or gain weight just before your periods?		
Last menstrual period:________________________		
Have you passed the menopause or change?		
Do you have hot flashes?		
Have you had any abortions?		
Have you ever had a miscarriage?		
Do you do self-breast exams?		
Have you had any lumps In your breasts?		
Have you had discharge from your nipples?		
Last mammogram: __________________________		
Have you had an abnormal mammogram?		
Have you had any unexplained bleeding or discharge from your vagina?		
How many times have you been pregnant?		
Full term: ________ Premature: ________		
Have you had multiple births?		
Number of living children: ___________________		
Have you ever had an abnormal Pap smear?		
Have you had uterine, cervical, or ovarian cancer?		
Have you had DES exposure?		

Have you used or currently using any of the following forms of contraception:

___ None ___ Attempting pregnancy
___ Abstinence ___ Vasectomy ___ Tubal
___ Depo-Provera ___ OCP ___ Patch
___ IUD ___ Diaphragm ___ Spermicide
___ Rhythm ___ Withdrawal

J. Additional Comments: ____________________________________
____
____
____
____
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____
____
____
____

Name: ____ Date of Birth: ____________________