Kearney County Health Services
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

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 HISTORY

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 problem	____	____	____________
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? ___yes ___no

If yes, what denomination? ____________________

Name: ____ Date of Birth: ______________

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
__Cough Medicine
__Digitalis or heart medicine
__Hormones or birth control pills
__Insulin or diabetic pills
__Iron or poor blood medications
__Laxatives
__Sleeping pills or tranquilizers
__Herbal/Alternative Medicine
__Thyroid medicine
__Stomach or digestive medicine
__Weight-reducing pills
__Blood-thinners or Coumadin
__Dilantin
__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 medication?
_____Yes _______No

If yes, please list medication and the reaction you had to them as well as what happened:

____

____

____

Any reaction to: ______Latex ______X-Ray Dye

Have you ever had blood transfusions?
______No ______Yes (please specify below)

Date	Procedure

Immunizations: Please give date

Have you had your childhood immunizations? ___yes ____no
Last flu shot? ____________________
Last pneumovax vaccination? ____________________
Last tetnus 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 form:	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

How many hours of sleep do you get on average? __________

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: ____________________

____

____

____

Name: ______________________________ Date of Birth: _______________

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?	_____	_____
Have there been any unusual weight gain or loss recently or change in your appetite?	_____	_____
Have you had any unexplained 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

Have you noticed:	Yes	No
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 change 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

Have you had:	Yes	No
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 a eye care provider? _____Last year _____Last 2 yrs _____Longer

D. ENT

Do you have:	Yes	No
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 nosebleeds?	_____	_____
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 yrs _____Longer

E. Respiratory

Do you have:	Yes	No
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 fingers 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 have 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 upset or have 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?	_____	_____

Name: ______________________________ Date of Birth: ______________

H. Genitourinary

Do you have:

	Yes	No
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 severe 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-size 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 ____

DepoProvera____ OCP____ Patch____

IUD____ Diaphragm____ Spermicide____

Rhythm____ Withdrawal_____

J. Additional Comments: ______________________________

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Name: ______________________________________ Date of Birth: ______________