ALABAMA DEPARTMENT OF PUBLIC HEALTH
ANNUAL PATIENT SELF HEALTH HISTORY FORM

Please complete the following information as best you can. Your answers will help us better understand your medical concerns and provide you the care you need. This information is confidential. Please feel free to ask staff if you have questions.

PATIENT LABEL

For Office Use Only: ❑ **Cancer Detection** ❑ **Family Planning** ❑ **Well Woman** ❑ **WISEWOMAN**

Name: **Age:** **Phone Number:** **Today's Date:**

What is the ***reason for your visit*** today?

Medical Information

Do you have ***any allergies***? ❑ Yes ❑ No If yes, please list. _____
What happened when you had the allergic reaction? _____

Have you been to any other health departments? ❑ Yes ❑ No If yes, what counties? _____
Have you been seen in the hospital or in the emergency room in the past year? ❑ Yes ❑ No
If yes, why? _____

Medical History: Check yes or no if you have ever been told you have any of the conditions listed below.

High Blood Pressure	❑ YES	❑ NO	Depression / Anxiety	❑ YES	❑ NO
Asthma / COPD	❑ YES	❑ NO	Diabetes	❑ YES	❑ NO
High Cholesterol	❑ YES	❑ NO	Heart Disease	❑ YES	❑ NO
Bowel / Liver Disorders	❑ YES	❑ NO	Migraine ❑ with Aura	❑ YES	❑ NO
Kidney Problems / Stones / UTIs	❑ YES	❑ NO	Stroke	❑ YES	❑ NO
Anemia / Clotting Disorders	❑ YES	❑ NO	Blood Clots / DVT / Varicose Veins	❑ YES	❑ NO
Blood Transfusions	❑ YES	❑ NO	Cancer (Type): _____	❑ YES	❑ NO
Thyroid Disease	❑ YES	❑ NO	Seizures / Epilepsy	❑ YES	❑ NO
Osteopenia / Osteoporosis	❑ YES	❑ NO	Sickle Cell Disease	❑ YES	❑ NO
Lupus/Immune Disorders/Rheumatoid Arthritis	❑ YES	❑ NO	Other: _____	❑ YES	❑ NO

Family Medical History: Please check ***all that apply***.

Check one of the following if no history: ❑ **No Family History of Conditions below** ❑ **Adopted - Do not know my family history**

	Mother	Father	Brother	Sister	Children	Mother's Mother	Mother's Father	Father's Mother	Father's Father
Heart Disease									
Diabetes									
Blood Clots / DVT									
Stroke									
High Cholesterol									
High Blood Pressure									
Heartburn/Ulcer									
Genetic disorder									
Arthritis									
Breast Cancer									
Colon Cancer									
Ovarian Cancer									
Uterine Cancer									
Prostate Cancer									
Hereditary Disease (Sickle Cell Disease, Cystic Fibrosis, thalassemia, hemophilia, etc.)									

Do you have any of the following symptoms? (Please check all that apply)

❑ Weight loss or gain	❑ Non-healing sores	❑ Urinary urgency	❑ Depression
❑ Fatigue	❑ Lumps / Swollen glands	❑ Pain/burning with urination	❑ Anxiety
❑ Fever, chills, or sweats	❑ Trouble swallowing	❑ Calf pain with walking	❑ Abdominal or pelvic pain
❑ Heartburn	❑ Breast lumps, Nipple Discharge, Pain	❑ Dizziness	❑ Vaginal / Vulvar itching, irritation, discharge
❑ Nausea	❑ Shortness of breath	❑ Fainting	❑ Vaginal dryness
❑ Skin rash	❑ Chest pain or discomfort	❑ Numbness/tingling/weakness of extremities	❑ Vaginal bleeding
❑ Vision / Hearing problems	❑ Constipation / Diarrhea / Blood in stool	❑ Headaches – migraine or tension	❑ Hot flashes
❑ Blurry or double vision	❑ Rectal bleeding	❑ Heat or cold intolerance	
❑ Hoarseness	❑ Urinary leakage	❑ Thirst	

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SURGICAL HISTORY: Have you ever had any surgeries? ❑ Yes ❑ No If yes, please list:		
OPERATIONS/PROCEDURES	When did you have it?	Where was it done (hospital, outpatient, etc.)?
1.		
2.		
3.		

Please list all medications you are currently taking. (This includes any over the counter medications, herbals and vitamins.)	
What medicines do you take?	How often? Once/day, at night, etc.
1.	
2.	
3.	
4.	
5.	

GYNECOLOGICAL HISTORY

1. At what age did your menstrual period begin? _____
2. What was the first day of your last period? _____
3. Have you had any bleeding or spotting after sex? ❑ yes ❑ no
4. When was your last mammogram? _____
5. Have you ever had an abnormal mammogram? ❑ yes ❑ no
6. Have you ever had an abnormal Pap Smear? ❑ yes ❑ no
   If yes, when? _____
7. Have you had any of the following? Please circle all that apply:
   Fibroids Endometriosis Ovarian Cysts Tumors

Have you had any of the following? (Check all that apply)

❑ Cervical cryo/laser surgery/LEEP ❑ Sexually Transmitted Infection
❑ Genital warts ❑ Uterine fibroids ❑ Pelvic Inflammatory Disease
❑ DES Exposure
❑ Other GYN problems _____

OBSTETRICAL HISTORY

1. Have you ever been pregnant? ❑ yes ❑ no
   If you have **NEVER** been pregnant, **skip to Sexual History.**
2. If yes, how many times have you been pregnant? _____
3. How many were:
   Full term? _____ Premature? _____ Stillborn? _____
4. How many times did you have:
   A miscarriage? _____ An abortion? _____ Tubal pregnancy?_____
5. Last delivery date: _____
6. Did you have any problems with your pregnancies? ❑ yes ❑ no
7. Are you currently breastfeeding? ❑ yes ❑ no

SEXUAL HISTORY

1. When did you last have sex? _____
2. Do you use condoms every time you have sex? ❑ yes ❑ no
3. How many sex partners have you had in the last 3 months? _____
   How many of these were new sex partners in the last 3 months? _____
4. How many sex partners have you ever had? _____
5. Do you have sex with (circle all that apply)
   Men Only Women Only Both Men and Women
6. Circle the ways you have sex: Vaginal Oral Rectal
7. Have you or your partner ever had a sexually transmitted disease?
   (Gonorrhea, Chlamydia, Syphilis, Genital Herpes, HIV, Trich, Genital Warts, Vaginal Infections, Hepatitis C, HPV, Other)? ❑ yes ❑ no
   If yes, please circle the STD. If other, List: _____
8. Have you had an HIV test? ❑ yes ❑ no
   If yes, when? _____ Was it negative? ❑ yes ❑ no

CONTRACEPTIVE HISTORY

1. What do you currently use for birth control? _____
2. Are you happy with your current method? ❑ yes ❑ no
   If no, what method do you want to try? _____
3. Are you having any problems with the birth control you are using now?
   ❑ yes ❑ no
4. Have you ever become pregnant while on birth control? ❑ yes ❑ no
   If yes, please list methods you were using: _____
5. Have you had a hysterectomy? ❑ yes ❑ no
   If yes, please tell why, _____
6. Have you had your tubes tied? ❑ yes ❑ no

SOCIAL HISTORY

1. Do you smoke tobacco, use e-cig or smokeless tobacco?
   ❑ current, # of years _____ ❑ never ❑ former, # of years _____ Packs per day: _____ Smokeless times per day _____
2. Do you drink alcohol? ❑ yes ❑ no How often? _____
3. Have you ever used recreational drugs? ❑ yes ❑ no If yes, what _____
   Have you ever injected any drugs? ❑ yes ❑ no If yes, what? _____
4. Does your partner use or inject drugs? ❑ yes ❑ no If yes, what?_____

I hereby certify that the above information is true and I have completed the above information to the best of my knowledge.

Patient Signature and/or Signature of Interpreter/Translator # Date

Reviewed By: (Nurse's Signature) Date

Reviewed By: (Provider's Signature) Date

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PATIENT LABEL

Nurse's Comments:

Reviewed By: (Nurse's Signature) _____ **Date** _____

Physician or Nurse Practitioner Comments:

Physician or Nurse Practitioner Signature _____ **Date** _____