SAN JUAN HEALTHCARE

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____
NAME First Middle Last

Education (yrs): High School ________________ College _____________
Other ____

Today's Date _____________ Date of Birth ______________
Single ___ Married/Partner __ Divorced ___ Widow(er) ____

Occupation(s) ____
Exposure to: noise__ chemicals__ dust__ other hazards_______________

CURRENT PROBLEM/CONCERNS: **HOW LONG HAS THIS BEEN A PROBLEM?**

____
____
____

SURGERIES (circle) **Date**
hysterectomy __________
hernia __________
gallbladder __________
appendectomy __________
breast surgery __________
C-section __________
other______________________________
____

ILLNESSES/INJURIES (circle)
hypertension
diabetes
epilepsy
asthma/allergies
heart attack/stroke
depression/anxiety
hepatitis
cancer ____________
glaucoma
thyroid
substance abuse
domestic violence
bladder/kidney problem
ulcer/stomach problem
accidents ____
other ____

MEDICATION ALLERGIES:
None that I know of
____
____
____
____

FAMILY HISTORY **IF LIVING** Age **IF DECEASED** Age at death/Cause

Father ____________________________ ______________________
Mother ____________________________ ______________________
Brother/Sister _______________________ ______________________
__________________________________ ______________________
__________________________________ ______________________
__________________________________ ______________________
Children __________________________ ______________________
__________________________________ ______________________
__________________________________ ______________________
__________________________________ ______________________

HAS ANY BLOOD RELATIVE EVER HAD: specify who
asthma/allergies ____________________________________
cancer/type ____
diabetes ____
heart trouble ______________________________________
high blood pressure _________________________________
stroke ____
substance abuse/alcoholism ___________________________
genetic disorder ____________________________________
colon cancer/colitis __________________________________
ulcers/stomach trouble _______________________________

Who lives with you in your household? ____

HABITS (circle all that apply)
Never smoked____________
CIGARETTES ___________pks/day
cigars, pipe, chewing tobacco, snuff
How long? ________________________
Year quit _________ # yrs. smoked ______

COFFEE/TEA/SODA: per day___________

ALCOHOLIC DRINKS:
never 1-2/mo. 1-2 week
1-2/day 3 or more daily

STREET DRUGS now/past
____
____

SEATBELTS: always sometimes never

EXERCISE: type ____________________________________
minutes per day________________ days per week ________

IF THERE A GUN IN THE HOUSE:
Is it unloaded?________ Is it locked up?___________

HEIGHT ___________ WEIGHT ________ WT. at age 20 _____ WT. (gain/loss) in the past year _______ DESIRED WT: _____
DATE OF LAST: tetanus shot _____ flu shot _____ physical _____ dental exam _____ eye exam ____ Pap smear ____ mammogram _____

PRESCRIPTION MEDS AND DOSAGE
____
____
____
____
____

NON-RX DRUGS, VITAMINS, AND HERBS etc
____
____
____
____
____

HEALTH HISTORY: Please complete both sides of form!

BODY SYSTEMS REVIEW: (Check any item that you are experiencing to any significant degree)

____unexplainable fatigue
____recurring fever/chills
____swollen glands
____night sweats
____weakness
____weight problem

____ chronic cough
____ cough blood
____ pneumonia
____ short of breath
____ wheezing

____ psoriasis
____ eczema
____ changing moles
____ skin cancer

____ unconsciousness
____ frequent/severe headaches
____ fainting
____ dizzy spells
____ seizures
____ head injury
____ paralysis

____ chest pain
____ heart murmur
____ palpitations
____ rheumatic fever
____ swollen ankles/feet
____ leg pain with walking
____ varicose veins
____ blood clots
____ anemia
____ blood disease

____ heartburn
____ ulcer
____ irritable bowel
____ black or bloody stools
____ rectal bleeding
____ abdominal pain
____ constipation/diarrhea
____ loss of appetite
____ change in bowel habits
____ hemorrhoids

____ trouble concentrating
____ memory problems
____ tense/irritable
____ trouble sleeping
____ feel depressed
____ work or family problems
____ thoughts about suicide
____ counselor seen

____ knee/ankle problem
____ shoulder/elbow problem
____ arthritis/joint pains
____ back/neck trouble
____ numbness/tingling

____ ear/hearing problem
____ eye/vision problem
____ glaucoma
____ cataracts
____ seasonal allergies
____ sinus trouble
____ dental problems
____ persistent hoarseness
____ trouble swallowing
____ thyroid problem

____ bladder/kidney infection
____ difficulty urinating
____ frequent urination
____ leaking urine
urinate at night ____ time(s)
____ kidney stone
____ infertility
____ sexual difficulties
____ prostate problems
____ penile discharge

type contraception used__________
domestic abuse ?_______________
previous sexual abuse? __________
WOMEN ONLY:
Menstrual History:
age of onset __________________
length of cycle ________________
date of last period ______________
history of abnormal Pap? ________
number of pregnancies __________
number of children _____________

unusual discharge? _____________
painful intercourse? ___________
periods painful? ________________
do you perform breast exam? ____
breast lump or cyst? ___________
menopausal symptoms? ________
taking/taken hormones? ________
Family History of:
osteoporosis?___
breast/cervical/uterine cancer?____

NUTRITION: How many servings of the following foods do you eat?

PER DAY: meals ___snacks ___ total cups of fluid ___ cups of milk ___ fruits & vegetables ___breads & starches ___

PER WEEK: eggs ____red meats ____ cheeses ____ fish ____ fried foods ____ desserts ____ chips/snack foods _____

SIGNATURE ____ **DATE** ___________