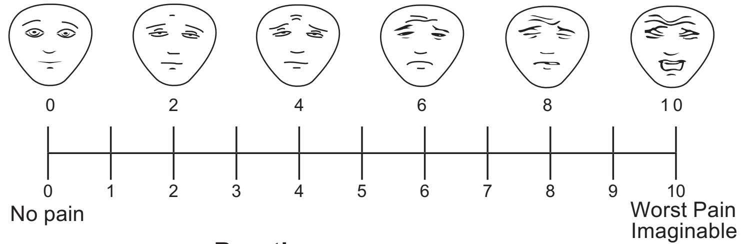
Virginia Mason Franciscan Health™	**Health History** CONFIDENTIAL Save form to your computer before completing it	**Name:**________________ **Birthdate:** ______________ **Today's Date:** ____________

Is this visit related to pain?

☐ No
☐ Yes, Select Pain Measurement Scale #:



Allergies

☐ **I have no known allergies**

I am allergic to:	Reaction

Yes	No	
☐	☐	I am allergic to latex
☐	☐	I am allergic to tape (tape/glue)
☐	☐	I am allergic to IV Contrast (X-ray Dye) (Contrast Dye)

Medications

Much of the information to complete below is on the label of your prescription bottles or can be obtained from your pharmacy or doctor's office. Be sure to include **ALL kinds of medications such as Vitamins, Herbal Medication, Supplements, Birth Control, Inhalers and Pain Relievers.**

☐ I take no Prescription Medications, Non-Prescription Medications or Other Medications.

Name of Medication	Dosage	When do you take it?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Social History

Alcohol Use: How many times in the past year have you had: Women: 4 or more drinks in a day? ____ Men under 65 years of age: 5 or more drinks in a day? ____ Men 65 years of age and older: 4 or more drinks in a day? ____	How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons? _______
Do you live with: ☐ Alone ☐ Sibling ☐ Child ☐ Significant other ☐ Father ☐ Spouse ☐ Mother ☐ Other	In the past 30 days, have you used tobacco? ☐Yes ☐No If Yes, are you interested in quitting? ☐Yes ☐No Number of cigarettes per day ____ Number of Years ____ Are you a former smoker? ☐Yes ☐No If Yes, at what age did you quit? ____ Number of cigarettes per day ____ Number of Years ____

Virginia Mason Franciscan Health

Health History

CONFIDENTIAL

Name:________________________
Birthdate: ___________________
Today's Date: ________________

FAMILY HISTORY

Please provide your **FAMILY's** health history below by checking the boxes for mother and/or father, and/or specifying other relatives (maternal or paternal grandfather, for example) on the line provided. Family includes mother, father, brothers, sisters, aunt, uncle, children and grandparents. You will be asked to provide **your own health history on the next page**

Mother	Father	Other Relative	Cancer
☐	☐	________	Breast Cancer
☐	☐	________	Colon Cancer
☐	☐	________	Colonic polyp
☐	☐	________	Leukemia
☐	☐	________	Lung cancer
☐	☐	________	Lymphoma
☐	☐	________	Malignant melanoma
☐	☐	________	Ovarian Cancer
☐	☐	________	Pancreatic Cancer
☐	☐	________	Skin Cancer
☐	☐	________	Thyroid Cancer
☐	☐	________	Prostate Cancer
☐	☐	________	Uterine Cancer

Mother	Father	Other Relative	Cardiovascular
☐	☐	________	Aortic aneurysm
☐	☐	________	Bleeding disorder
☐	☐	________	Blood clots
☐	☐	________	Cerebral aneurysm
☐	☐	________	Congestive Heart Failure
☐	☐	________	Coronary Artery Disease
☐	☐	________	Disorder of Heart Rhythm
☐	☐	________	High Cholesterol
☐	☐	________	Heart Attack
☐	☐	________	High Blood Pressure
☐	☐	________	Sudden Death

Mother	Father	Other Relative	Endocrine
☐	☐	________	Diabetes mellitus
☐	☐	________	Diabetes mellitus Type 1
☐	☐	________	Diabetes mellitus Type 2
☐	☐	________	Graves' Disease
☐	☐	________	Hypothyroidism
☐	☐	________	Thyroid disorder

Mother	Father	Other Relative	Eye
☐	☐	________	Cataract
☐	☐	________	Glaucoma
☐	☐	________	Macular degeneration
☐	☐	________	Partial Blindness
☐	☐	________	Retinal detachment

Mother	Father	Other Relative	Other Not Listed
☐	☐	________	________________
☐	☐	________	________________

Mother	Father	Other Relative	Gastrointestinal (GI)
☐	☐	________	Colitis
☐	☐	________	Crohn's disease
☐	☐	________	GI Bleeding
☐	☐	________	Pancreatitis
☐	☐	________	Acid Reflux
☐	☐	________	Ulcerative Colitis

Mother	Father	Other Relative	Kidney
☐	☐	________	Renal failure and on Dialysis
☐	☐	________	Kidney Disease
☐	☐	________	Kidney Stone
☐	☐	________	Multi-cystic kidney

Mother	Father	Other Relative	Neurologic
☐	☐	________	Alzheimer's disease
☐	☐	________	Developmental Delays
☐	☐	________	Migraines
☐	☐	________	Seizure
☐	☐	________	Stroke

Mother	Father	Other Relative	Ortho/Rheumatologic
☐	☐	________	Arthritis
☐	☐	________	Gout
☐	☐	________	Osteoporosis
☐	☐	________	Rheumatoid Arthritis
☐	☐	________	Rheumatology Disorder

Mother	Father	Other Relative	Psychiatric
☐	☐	________	Alcoholism
☐	☐	________	Bipolar Disorder
☐	☐	________	Depression
☐	☐	________	Drug Abuse
☐	☐	________	Schizophrenia
☐	☐	________	Suicide

Mother	Father	Other Relative	Respiratory
☐	☐	________	Allergies
☐	☐	________	Asthma
☐	☐	________	COPD
☐	☐	________	Pulmonary Tuberculosis
☐	☐	________	Sleep Apnea

☐ NONE ARE APPLICABLE TO MY FAMILY

Virginia Mason Franciscan Health™

Health History **CONFIDENTIAL**

Name:________________________
Birthdate: ___________________
Today's Date: ________________

PATIENT HEALTH HISTORY

Please complete this form to the best of your ability by checking any box that applies and including the approximate year of onset.

Cancer	Year of Onset
☐ Bladder cancer	____________
☐ Breast cancer	____________
☐ Cervical cancer	____________
☐ Chemo-therapy	____________
☐ Colon cancer	____________
☐ Colon poyp	____________
☐ Leukemia	____________
☐ Lung cancer	____________
☐ Lymphoma	____________
☐ Ovarian cancer	____________
☐ Pancreatic cancer	____________
☐ Prostate cancer	____________
☐ Radiation therapy	____________
☐ Skin cancer: melanoma	____________
☐ Skin cancer: other	____________
☐ Thyroid cancer	____________
☐ Uterine cancer	____________
Cardiovascular	
☐ Anemia	____________
☐ Aortic Aneurysm	____________
☐ Atrial Fibrillation	____________
☐ Bleeding disorder	____________
☐ Blood clots/DVT	____________
☐ Carotid artery blockage	____________
☐ Cerebral aneurysm	____________
☐ Congestive heart failure	____________
☐ Coronary artery disease	____________
☐ Disorder of heart rhythm	____________
☐ Heart valve problem-Aortic	____________
☐ Heart valve problem-Mitral	____________
☐ High blood pressure	____________
☐ High cholesterol	____________
☐ Peripheral artery disease	____________
☐ Stroke	____________
☐ TIA (Mini-stroke)	____________
Endocrine	____________
Diabetes Type 1 ☐ Type 2 ☐	____________
☐ Graves' Disease	____________
☐ Hyperthyroidism	____________
☐ Hypothyroidism	____________
☐ Pre-diabetes/impaired fasting glucose	____________
☐ Thyroid nodule(s)	____________
	____________
Eye/Ear	____________
☐ Amblyopia	____________
☐ Cataract	____________
☐ Glaucoma	____________
☐ Hearing loss	____________
☐ Macular degeneration	____________
☐ Strabismus	____________
☐ Partial Blindness	____________
Gynecology	
☐ History of abnormal pap	________

Gastrointestinal (GI)	Year of Onset
☐ Acid Reflux/heartburn	____________
☐ Cirrhosis of the liver	____________
☐ Crohn's disease	____________
☐ GI Bleeding	____________
☐ Irritable bowel syndrome	____________
☐ Pancreatitis	____________
☐ Ulcerative colitis	____________
Infections	
☐ AIDS	____________
Hepatitis B ☐ or C ☐	____________
☐ HIV	____________
☐ MRSA(Resistant Staph)	____________
☐ Sexually Transmitted Disease	____________
Kidney	
☐ Kidney Stone(s)	____________
☐ Renal insufficiency/failure	____________
Neurologic	
☐ Alzheimer's Dementia	____________
☐ Dementia, not Alzheimer's	____________
☐ Learning Disability	____________
☐ Migraines	____________
☐ Multiple Sclerosis (MS)	____________
☐ Parkinson's	____________
☐ Seizure	____________
Orthopedic/Rheumatologic	
Arthritis hip☐ knee☐	____________
☐ Gout	____________
Fracture hip☐ stress☐	____________
☐ Lupus	____________
☐ Osteoporosis	____________
☐ Rheumatoid arthritis	____________
☐ Scoliosis	____________
Other	
☐ Psoriasis	____________
☐ Seasonal Allergies	____________
Psychiatric	
☐ Anxiety disorder	____________
☐ Attention deficit disorder	____________
☐ Bipolar disorder	____________
☐ Depression	____________
☐ PTSD	____________
☐ Schizophrenia	____________
Respiratory	
☐ Asthma	____________
☐ COPD	____________
☐ Pulmonary Tuberculosis	____________
☐ Sleep Apnea	____________
Other Not Listed	
☐ ________________	____________

☐ **I have *NONE* of the problems listed**

Virginia Mason Franciscan Health

Health History

CONFIDENTIAL

Name: ______________________

Birthdate: ___________________

Today's Date: ________________

PATIENT SURGICAL HISTORY

Please indcate to the best of your ability, any surgical procedures you have by checking any box that apply. Please include the year in which the surgery occured.

Difficulty with IV insertion ☐ **Yes** ☐ **No** **(Provider to review)**

General/ Other — Year

☐ Appendectomy __________
☐ Gall Bladder surgery __________
☐ Hemorrhoids surgery __________

☐ Left Kidney Removal __________
☐ Right Kidney Removal __________
☐ Mastectomy bilateral __________
☐ Left Mastectomy __________
☐ Right Mastectomy __________
☐ Organ Transplant __________
☐ Prostate TURP __________
☐ Prostatectomy for Cancer __________
☐ Left Thyroidectomy __________
☐ Right Thyroidectomy __________
☐ Tonsillectomy __________
☐ Weight Loss Surgery __________

Eye/Ear/Nose/Throat __________

☐ Left Cataract removal __________
☐ Right Cataract removal __________
☐ Left Cochlear implant __________
☐ Right Cochlear implant __________
☐ Sinus surgery __________

Gynecology

☐ Bladder "lift" or sling __________
☐ Lt Breast biopsy/cyst removal __________
☐ Rt Breast biopsy/cyst removal __________
☐ Left Breast reconstruction __________
☐ Right Breast reconstruction __________
☐ Cautery of cervix __________
☐ Cesarean Section __________
☐ Hysterectomy (cervix removed) __________
☐ Hysterectomy (cervix not removed) __________
☐ Left ovary removal __________
☐ Right ovary removal __________
☐ Tubal ligation/sterilization __________

Anesthesia (for surgery)

☐ Complications or reactions __________
(Provider to review)

Year

Cardiovascular

☐ Aneurysm repair __________
☐ Coronary Angioplasty/Stent __________

☐ Coronary artery bypass __________
☐ Valve Replacement - Aortic __________
☐ Valve Replacement - Mitral __________
☐ Pacemaker or Defibrillator __________

Orthopedic

☐ Left carpal tunnel repair __________
☐ Right carpal tunnel repair __________

☐ Left Hip Replacement __________
☐ Right Hip Replacement __________

☐ Left Knee Arthroscopy __________
☐ Right Knee Arthroscopy __________

☐ Left Knee Replacement __________
☐ Right Knee Replacement __________

☐ Left Rotator Cuff repair __________
☐ Right Rotator Cuff repair __________

☐ Left Torn Ligament repair __________
☐ Right Torn Ligament repair __________

☐ Left Wrist Arthroscopy __________
☐ Right Wrist Arthroscopy __________

Neurologic

☐ Laminectomy __________
(Spine Surgery)

Other Not Listed

☐ __________________ __________
☐ __________________ __________

☐ **I have reviewed the above and have had *NONE* of the surgeries listed or added.**

VMMC Form 903441DPC (04-24)