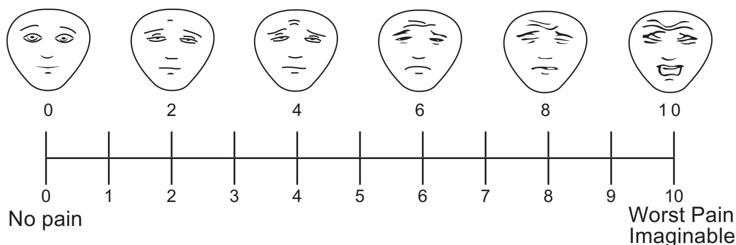
Health History

CONFIDENTIAL

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 ____

VMMC Form 903441 (04-20)

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

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**

VMMC Form 903441 (02-19)

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)**	__________

Cardiovascular	Year
☐ 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 903441 (02-19)