



WESTERN WISCONSIN MEDICAL ASSOCIATES

PATIENT HEALTH HISTORY

DATE COMPLETED

NAME, AGE, DOB, OCCUPATION, SIGNIFICANT OTHER

Please indicate if you have had any of the following in the past 3 months:

SYSTEM REVIEW:

General, Respiratory, Musculoskeletal, Eyes, Gastrointestinal, Skin, Ears, Nose, Throat, Mouth, Urologic / Gynecologic, Neurologic, Endocrine, Hematologic, Cardiovascular, Allergic / Immunologic, Social / Family

CONTINUES ON REVERSE

Check here if your health history hasn't changed since your last visit.

Present Concerns: _____

Current Medical Conditions: _____

Previous Hospitalizations: _____

Previous Surgeries: _____

Allergies: _____

Current Medications: _____

OBSTETRIC HISTORY: (Fill in as appropriate)

Pregnancy Date(s)	Outcome (i.e. Vaginal Birth)
_____	_____
_____	_____
_____	_____

SEXUAL HISTORY: (Circle answers and fill in as appropriate)

Are you sexually active? YES NO NOT CURRENTLY

Sexual Partners: MALE(S) FEMALE(S) BOTH

Method of Contraception: _____

HABITS: (Circle answers and fill in as appropriate)

Tobacco? YES QUIT NEVER
SMOKE CHEW SNUFF
Amount Per Day _____
Years Spent _____

Alcohol? YES QUIT NEVER
Times per week _____
Amount per time _____

Ever felt like you ought to cut down? YES NO
Have people annoyed you by criticizing your drinking? YES NO
Have you felt guilty about your drinking? YES NO
Have you ever had an 'eye-opener' morning drink? YES NO

Other Drugs? YES QUIT NEVER
(i.e. Marijuana) Which drugs? _____

Do you exercise regularly? YES NO
Which exercises? _____

How many times per week? _____

Do you follow a special diet? YES NO
Know your cholesterol levels? YES NO
Total _____ HDL _____ LDL _____ Triglyceride _____

Wear seat belts? YES NO SOME
Wear a bike helmet? YES NO SOME
Have a smoke detector? YES NO
Carbon monoxide detector? YES NO
Adult / infant CPR training? YES NO
If you own a gun, is it secured? YES NO N / A
(Women) Self Breast Exam? YES NO
(Women) Screening Mammogram? YES NO
(Men) Self Testicular Exam? YES NO

FAMILY: (Circle answers and fill in as appropriate)

	LIVING	AGE	HEALTH CONDITIONS
MOTHER _____	Y N	_____	_____
FATHER _____	Y N	_____	_____
SIBLINGS			
1. M _____ F _____	Y N	_____	_____
2. M _____ F _____	Y N	_____	_____
3. M _____ F _____	Y N	_____	_____
4. M _____ F _____	Y N	_____	_____
5. M _____ F _____	Y N	_____	_____
6. M _____ F _____	Y N	_____	_____
CHILDREN (List names of children)			
1 _____	Y N	_____	_____
2 _____	Y N	_____	_____
3 _____	Y N	_____	_____
4 _____	Y N	_____	_____
5 _____	Y N	_____	_____