Barrett Clinic P.C.
PRIMARY & PREVENTATIVE HEALTHCARE

DATE: _____

Health History Form

Your answers on this form will help your health care provider get a better understanding of your medical concerns and conditions. If you cannot remember specific detail or dates, please provide your best guess. If you are uncomfortable with any of the questions, do not answer. Thank you!

Patient Name: _____ Date of Birth: _____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Partnered ☐ Divorced ☐ Widowed

Language: ☐ English ☐ _____

Ethnicity: Are you Hispanic/Latino? ☐ Yes ☐ No

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White

Medications: Please list (or provide us your own record to copy) all prescription and non-prescription, vitamins, herbal, etc. Use the back of this form if you need more room. ☐ No medications

Medication/Vitamin	Dose/strength (mg/pill)	How often?

Allergies: list any allergies or intolerance to medications or foods. ☐ None

Do you have a latex allergy? ☐ NO ☐ YES

Medication/Food	Reaction

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Immunizations: Check off any vaccinations you have had. Add a year, if known.

Vaccine	Year, if known		Vaccine	Year, if known
Tetanus (Td)			Influenza (flu shot)	
Tetanus with pertussis			MMR	
Varicella (chicken pox)			Pneumovax (pneumonia)	
Zostavax (shingles)			Prevnar 13 (pneumonia)	
Hepatitis A series			Meningitis	
Hepatitis B series			HPV (human papilloma virus)	

Health Maintenance Screening tests: Date of most recent record.

Cholesterol Date: _____ abnormal? __ Yes __ No
Colonoscopy/flex sig Date: _____ abnormal? __ Yes __ No
Bone density scan Date: _____ abnormal? __ Yes __ No
Women: Mammogram Date: _____ abnormal? __ Yes __ No
Pap smear Date: _____ abnormal? __ Yes __ No
Men: PSA Date: _____ abnormal? __ Yes __ No

Personal Medical History:

___ High Blood Pressure
___ High Cholesterol
___ Diabetes
___ Cancer, type _____ Year _____
type _____ Year _____
Other history: _____ _____
_____ _____
_____ _____
_____ _____

Women's Health History

Do you see an OB/GYN provider? __ No __ Yes, name: _____
Total # of pregnancies:_____ # of births:_____
Any pregnancy complications? __ No __ Yes, complication:_____
Date of last known menstrual period:_____
Age at beginning of menstrual periods:_____
Age at end of menstrual periods (menopause):_____

Surgical History:

Surgery	Year of surgery	Reason

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Other health issues:

Tobacco use
Smoke cigarettes: ☐ Never
☐ Former
Quit date: _____ How many years did you smoke? ____
Approx. how many packs per day? _____
☐ Current
Packs per day ____ # of years _____
Other tobacco: ☐ Pipe ☐ Cigar ☐ snuff ☐ chew

Alcohol use
Do you drink alcohol? ☐ Yes ☐ No
# of drinks/week_____ ☐ Beer ☐ wine ☐ liquor

Drug use
Do you use marijuana or recreations drugs? ☐ Yes ☐ No
Have you ever used needles to inject drugs ☐ Yes ☐ No

Sexual Activity
Sexually involved currently ☐ Yes ☐ No
Sexual partner(s) is/are/have been ☐ female ☐ male
Birth control method(circle all that apply) ☐ none needed
Condom, oral contraception, vasectomy, diaphram, implanted

Exercise: Do you exercise regularly? ☐ No ☐ Yes
What kind of exercise? _____
_____
How long(minutes)?_____ How often? _____

Diet: How would you rate your diet? ☐ regular ☐ vegan
☐ vegetarian ☐ gluten free ☐ diabetic ☐ cardiac

Safety:
Do you use a seatbelt consistently ☐ Yes ☐ No
Does your home have a working smoke detector? ☐ Yes ☐ No
Is violence at home a concern for you? ☐ Yes ☐ No
Do you wear a helmet on a bike? ☐ N/A ☐ Yes ☐ No
Do you wear sunscreen regularly? ☐ Yes ☐ No
Have you completed a Advance Directive for Health Care (ADHC), living will, or Physician orders for Life sustaning Therapy (POLST) ☐ Yes ☐ No

Social History Occupation (or prior occupation) _____ retired/ unemployed/disabled
Employer:_____ Years of education or highest degree:_____
Spouse/partner's name: _____ # of children: _____ Ages if under 19: _____
# of grandchildren:_____ # of great grandchildren:_____
Who lives with you? _____
Leisure activities, group involvement, religion, volunteer work, recent travel: _____
_____

_____

Thank you for taking the time to complete this form