RILEY COUNTY HEALTH DEPARTMENT

HEALTH HISTORY FORM B

ASSURANCE OF CONFIDENTIALITY: This medical record is confidential and will not be released to anyone without your written consent except as may be required by law.

Name ____ Date of Birth ______________ Age ______

Pronoun:___________ Sex:__________ Gender:_________

Are you allergic to any medications, food, other? ______ No ______ Yes List: __________________

GENERAL HEALTH

Have you ever had/do you have?

No	Yes		No	Yes	
☐	☐	Diabetes/Thyroid Problem	☐	☐	Problems with kidneys or bladder
☐	☐	Seizures	☐	☐	Cancer
☐	☐	Heart attacks or strokes	☐	☐	High blood pressure
☐	☐	Hepatitis (skin turned yellow) or gallbladder problems	☐	☐	Problems with muscles/bones
☐	☐	Depression	☐	☐	Migraines or bad headaches
☐	☐	Blood clot in blood vessels (leg or lung)	☐	☐	Blood transfusions
☐	☐	Problems with vision or hearing	☐	☐	Shortness of breath

☐ ☐ Have you ever had any other medical conditions, surgery or been hospitalized? If yes, explain ____.

Do you chew or smoke tobacco? _____ No _____ Yes

How many cigarettes/ cans do you smoke/chew a day? _____ How long have you chewed/ smoked? _____

How many alcoholic beverages do you drink per day_____, week _____, month ____?

Are you worried about your alcohol use? ____No ____Yes

Do you currently use street drugs? ____No _____ Yes

If yes, which ones and how many times a week? ____

Do you or have you ever used injectable drugs? ______ No ______ Yes

If yes, how often? _____________________ Last time used? ____________________________

List the medications you are taking, how often and how much. ***Include prescriptions, over the counter (Ibuprofen, Tylenol), herbs, & vitamins ____

How many times a week do you exercise? ____ Per day, how many Fruits ___Veg ___ Dairy___ Grains___ Meat ___eaten?

If age 50 or older, had you had a colon cancer screening? _____ No ____ Yes

IMMUNIZATIONS

Please give the dates of your last immunizations. (A tetanus booster is recommended every 10 years.)

_____ MMR (1 or 2 doses) ____ Td/TDaP ____ Hepatitis B Series Other, list ______________

FAMILY HISTORY

Are you adopted? _____ No _____ Yes (If yes, and you do not know your family history, you are done with this section.)

Have any of your blood relatives had the following conditions? Please say who they are (mother, father, brother, sister)

____ Diabetes _______________ ____ High cholesterol/triglycerides _________ ____ Sickle Cell Anemia__________

___ Cancer ______Type_______ ____ High blood pressure ________________ ____ Stroke ____________________

___ Phlebitis/clots in veins_______ at what age __________? _____ Heart disease/attack ________ at what age? _________

If born before 1971, did your mother receive DES (hormones) to prevent miscarriage? _______No ______ Yes

PSYCHOSOCIAL

Do you have any problems at home, work, or school that are bothering you? _____No _____ Yes

If yes, please explain ____

PREGNANCY/ PARENTING

How many children have you fathered? ____ Do you have plans for pregnancy/adoption in the next year? ______

(OVER)

SEXUAL

How old were you when you first had intercourse? _______ Was it consensual? ____ If no, explain ________________

When you were young did someone ever touch your penis or rectum in a sexual way? _______No ______Yes

Do you have trouble having or maintaining an erection? _____ No _____ Yes

If yes, please describe: ____

Were/are your sexual partners: ☐ men ☐ women ☐ IV drug users ☐ partner with multiple partners or at risk for HIV/STD ☐ Sexual assault situation ☐ Other :_________________________

Have you tested positive and/or been treated for a sexually transmitted disease in the past year? ___ No ____ Yes

If yes, when and what disease? ____

Have you had a new sexual partner or more than one sexual partner in the last year? ____ No ____ Yes How many? _____

How many partners have you had in your lifetime? _____________________________________

Have you ever been physically abused (hit, kicked, slapped)? _______ No _______ Yes ____Current situation?

Have you ever been emotionally abused (threatened, made to feel worthless)? _____ No _____ Yes ____ Current situation?

Has anyone, including a partner or family member ever forced you to have sex? ____No _____ Yes __ Current situation?

What types of sex do you have? ☐ Oral ☐ Anal ☐ Vaginal ☐ None ☐ Other :____________________

What do you do to protect yourself from being infected with HIV/STDs? _________________________

CONTRACEPTIVES

If your partner(s) is/are anatomically female, are you or your sex partner using a birth control method? ___ No __ Yes

What method? ____

CONSENT FOR EXAMINATION AND/OR TREATMENT

____ ____

Signature Date

____ ____

Signature Date

____ ____

Signature Date

____ ____

Signature Date

For office use only

Reviewed by: ___________________________________ Date___________________________________

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