# HAND FAMILY HEALTHCARE

Aloha Hand, DNP, FNP-BC

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & COMPREHENSIVE HEALTH HISTORY FORMS

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# COMPREHENSIVE HEALTH HISTORY

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the provider during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date: ____________________

First Name: ____________________ Middle: _____________ Last: ____________________

Address _______________________ City _______________ State ____ Zip Code _________

Home Phone____________________ Work ___________________ Cell ________________

Email _______________________________________

SSN __________________________________________

Age ______ Date of Birth ___/____/______

Gender: Male ___ Female ___ M/F _____Unknown_____

Marital Status:

Single___ Married _____ Divorced _____ Widowed______ Long term partnership________

Emergency Contact: Name ____________________________________________________

Relationship ______________________________ Phone ____________________________

Address _____________________________________________________________________

Responsible party (if minor) name_______________________________________________

Address _____________________________________________________________________

Phone number _____________________________________

Referred by: _________________________________________________________________

Employer___________________________ Hours per week _______________ Retired ________

Genetic Background: please circle appropriate one:

African American Hispanic Mediterranean Asian

Native American Caucasian Norther European Other

## PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

| ILLNESSES | WHEN/ONSET | COMMENTS |
|---|---|---|
| Anemia | | |
| Arthritis | | |
| Asthma | | |
| Bronchitis | | |
| Cancer | | |
| Chronic Fatigue Syndrome | | |
| Chron's Disease | | |
| Ulcerative Colitis | | |
| Diabetes | | |
| Emphysema | | |
| Epilepsy, Convulsions, seizures | | |
| Gout | | |
| Heart attack, Angina | | |
| Heart Failure | | |
| Hepatitis | | |
| Herpes Lesions/Shingles | | |
| High cholesterol/triglycerides | | |
| High blood pressure | | |
| Irritable bowel | | |
| Kidney stones | | |
| Mononucleosis | | |
| Pneumonia | | |
| Rheumatic Fever | | |
| Sinusitis | | |
| Sleep Apnea | | |
| Stroke | | |
| Thyroid Disease | | |
| Whooping Cough | | |

| Other (describe) | | |
|---|---|---|
| Other (describe) | | |
| | | |
| **INJURIES** | **WHEN** | **COMMENTS** |
| Back injury | | |
| Broken bones/fractures | | |
| Neck injury | | |
| Other (describe) | | |
| Other (describe) | | |
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| **SURGERIES** | **WHEN** | **REASON** |
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# CURRENT HEALTH STATUS/CONCERNS

| Problem | Date of Onset | Severity/Freq | Treatment | Success |
|---|---|---|---|---|
| *Example: Headaches* | *May 2008* | *2 times per week* | *Acupuncture/Aspirin* | *Mild improvement* |
| | | | | |
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**Current Pharmacy: ____________________________________________**

**ALLERGIES:** Please list all allergies to medications, vitamins, minerals, or other nutritional supplement. _____________________________________________________________________

**List all medications. Include all over the counter non-prescription drugs.**

**MEDICATIONS**

| Medication name | Date started | Date stopped | Dosage |
|---|---|---|---|
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**List all vitamins, minerals, and any nutritional supplements that you are taking now. If possible, indicate the dosage.**

| Type | Date started | Dosage |
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# LIFESTYLE HISTORY

How much of the following do you consume each week?

| | |
|---|---|
| Cups of Coffee containing caffeine | |
| Cups of decaffeinated coffee or tea | |
| Cups of tea containing caffeine | |
| Diet Soda | |

| Soda with caffeine | |
|---|---|
| Soda without caffeine | |

**TOBACCO HISTORY**

Have you ever used tobacco?  Yes____ NO____

If yes, what type?  Cigarette ____ Smokeless _____ Cigar _____ Pipe_____ Patch/Gum_______

How much? _____________________________________________________

Number of years? ____________ If not a current user, year quit ______________

Attempts to quit ___________

Are you exposed to 2nd hand smoke regularly?  If yes, please explain ______________________

_______________________________________________________________________________

**ALCOHOL INTAKE**

Have you ever used alcohol?  Yes ____ No _______

If yes, how often do you now drink alcohol?

______ No longer drink alcohol

______ Average 1-3 drinks per week

______Average 4-6 drinks per week

______Average 7-10 drinks per week

______ Average > 10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others)? Yes ___ No____

Have you ever had a problem with alcohol?  Yes ____ No ____

If yes, indicate time period (month/year) From _________to_________

**OTHER SUBSTANCES**

Do you currently or have you previously used recreational drugs? Yes ____ No______

If yes, what type(s) and method? (IV, inhaled, smoked, etc) _____________________________

_______________________________________________________________________________

**SLEEP AND REST HISTORY**

Average number of hours that you sleep at night? Less than 10___ 8-10 ____ 6-8 _____ less than 6 _____

Do you:

Have trouble falling asleep? _______

Snore? _______

Feel rested upon wakening? _______

Use Sleeping Aids? _______

Have problems with insomnia? _____

**EXERCISE HISTORY**

Do you exercise regularly? Yes_____ No_____

If yes, please explain: ____________________________________________________________

______________________________________________________________________________

**SOCIAL HISTORY**

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your healthcare provider is aware of any stressful influences that may be impacting your health. Informing your provider allows him/her to offer you supportive treatment options and optimize the outcome of your healthcare.

**STRESS/PSYCHOSOCIAL HISTORY**

Are you overall happy? Yes ____ No____

Do you feel you can easily handle the stress in your life? Yes ____ No ____

If no, do you believe that stress is presently reducing the quality of life? Yes ____ No_____

If yes, do you believe that you know the source of your stress? Yes ____ No_____

If yes, what do you believe it to be? ________________________________________________

Have you ever contemplated suicide? Yes ___ No _____

If yes, how often? _____________ When was the last time? ________________

Have you ever sought help through counseling? Yes ___ No ____

If yes, what type? (e.g., pastor, psychologist, etc) _____________________________________

Did it help? ______________

Is there anything you would like to discuss with the provider today that you feel cannot indicate here? Yes ____ No ____

**IMMUNIZATION HISTORY**

Please indicate if you have been vaccinated against any of the following diseases:

| | Yes | No | Current/Not current |
|---|---|---|---|
| Smallpox | | | |
| Tetanus | | | |
| Diptheria | | | |
| Pertussis | | | |
| Polio | | | |
| Mumps | | | |
| Measles | | | |
| Rubella | | | |
| Typhoid | | | |
| Cholera | | | |
| Flu | | | |
| Pneumonia | | | |
| Shingles | | | |

# FEMALE MEDICAL HISTORY

OBSTETRICS HISTORY

Number of Pregnancies______ C section Vaginal deliveries

GYNECOLOGICAL HISTORY

Age at first menses?________ Frequency________ Length______________________________

Painful: Yes______ No______

Date of last menstrual period ____/_____/_____

Do you currently use contraception? Yes____ No______ If yes, please indicate which form:

**Non-hormonal**

Condom Diaphragm IUD Partner Vasectomy

Other (please describe) __________________________________________________________

**Hormonal**

Birth control pills   Patch  Nuva Ring

Other (please describe) ________________________________________________________

Even if you are not currently using contraception, but have used hormonal birth control in the past, please indicate which type and for how long ____________________________________

Are you menopausal? Yes ______ No _________ If yes, age of menopause ________________

Do you currently take hormone replacement? Yes ____ No _________ If yes, what type and for how long? ________________________________________

Estrogen     Ogen     Estrace     Premarin     Progesterone     Provera     Other

DIAGNOSTIC TESTING

Last Pap test ___/___/_____ Normal____________ Abnormal ________________

Last Mammogram ___/___/____ Breast Biopsy? Date ___/____/____

Date of last bone density ___/___/_____ Results: High ____ Low _____

Within normal range ____

Thank you for taking the time to complete this health history medical questionnaire.  The information derived from all these forms will provide invaluable data in identifying health concerns.

We look forward to helping you achieve lifelong health and well-being.

Sincerely,
Dr. Aloha Hand, DNP, FNP-BC and staff