



SHENANDOAH COMMUNITY HEALTH

Health Information

Name: _____ Date of Birth: _____

What type of work do you do? _____

When was your last immunization for:

Tetanus _____ / _____ / _____ Pneumonia _____ / _____ / _____ Influenza (Flu) _____ / _____ / _____

Women:

Have you ever been sexually active? Yes / No

Are you currently sexually active? Yes / No

Number of pregnancies: _____

Age first pregnancy: _____

Number of full term births: _____

Number of preterm births: _____

Number of abortions: _____

Number of miscarriages: _____

Number of ectopic pregnancies: _____

Number of living children: _____

Date of your last mammogram _____ / _____ / _____

Number of Cesarean sections: _____

Number of vaginal deliveries: _____

Complications: _____

Current birth control method _____

If Birth Control Pill, name the type: _____

Any problems? _____

First day of Last Menstrual Period _____ / _____ / _____

Date of your last Pap Test _____ / _____ / _____ Normal? Yes / No

Have you had a hysterectomy? Yes / No

Are you Pre/Post Menopausal? Yes / No

Date of your last colonoscopy _____ / _____ / _____

Men:

Have you ever been sexually active? Yes / No

Are you currently sexually active? Yes / No

Do you check your testicles monthly? Yes / No

Date of your last colonoscopy _____ / _____ / _____

Children:

Any problems during mother's pregnancy? _____ Birth weight? _____

Any problems during labor/delivery? _____

**Please bring a copy of the child's immunization record*

All:

Are you exposed to physical or emotional abuse? Yes / No

Are you exposed to any domestic violence? Yes / No

Do you need assistance with walking? Yes / No

Do you wear glasses/contact lenses? Yes / No

Do you wear hearing aids? Yes / No

Do you need assistance reading? Yes / No

Do you need assistance writing? Yes / No

Did someone help you complete this form? Yes / No

Do you have any cultural/religious beliefs that effect your care? Yes / No

What is your preferred learning method? *(Please circle one)*

Audio Materials / Demonstration / Verbal Explanation / Video Material / Written Material

Do you have Advanced Directives completed? Yes / No

Do you have smoke detectors in your home? Yes / No

Do you have any guns in your house? Yes / No

What medications do you take? Include prescription, over-the-counter, and herbal supplements: _____

Are you allergic to any medications, anesthetics (numbing medicines), iodine, latex, tape, or foods, anything else? Yes / No

Name: _____ Date of Birth: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Have you ever been hospitalized overnight? Yes / No When and for what reason? _____

Have you ever had surgery? Yes / No When and for what reason? _____

Do you have any current or past medical conditions such as: *(Please circle)*

- | | |
|---|---|
| Headaches | Hearing difficulty |
| Back Trouble | HIV |
| Ulcers | Bowel Trouble |
| Trouble swallowing | Diarrhea |
| Arthritis | Infertility |
| Anemia | Constipation |
| Heart Trouble (Chest Pain, Irregular Heartbeat) | Urinary Problems (Infection, Loss of Bladder Control) |
| Hepatitis | Breast Problems |
| Stroke | Cancer |
| High Blood Pressure | Thyroid Problems |
| Broken Bones | Sexual Problems |
| Asthma | Back Trouble |
| Emphysema | Seizures |
| Diabetes | Mental Health Issues (Depression, Anxiety, Stress) |
| Pneumonia | Vision problems (Blurry Vision, Glaucoma, Cataracts) |
| Tuberculosis | Other: _____ |
| Drug or Alcohol Addiction | _____ |
| Heartburn | _____ |

Does anyone in your family (children, parents, and siblings) have a history of: (If so, please state who)

- | | |
|------------------------------|----------------------------|
| Asthma/COPD _____ | High Blood Pressure _____ |
| Cancer _____ | Mental Health Issues _____ |
| Diabetes _____ | Stroke _____ |
| Drug/Alcohol Addiction _____ | Thyroid Issue _____ |
| Heart Issues _____ | |
| Other: _____ | |

Do you smoke or use tobacco? Yes/No How much per day? _____ Do you live with someone who smokes? Yes / No

Do you vape? Yes / No How much per day? _____

How much alcohol do you drink per day? _____

How much caffeine do you drink per day? _____

Do you use marijuana or other drugs? Yes / No Which drugs? _____

