Selah Family Medicine
202 W. Naches Ave.
Selah, WA 98942
(509) 697-5511

HEALTH HISTORY

(All information is strictly confidential)

Name:_____Today's Date_____

Age:_____Birthdate_____Date of your last physical examination_____

Spouse's Name:_____ Do you have a living will? _____Yes _____No

SYMPTOMS Check (x) symptoms you currently have or have had in the past year

GENERAL
____Chills
____Depression
____Dizziness
____Fainting
____Fever
____Forgetfulness
____Headache
____Loss of Sleep
____Loss/Gain of weight
____Nervousness
____Numbness
____Sweats

MUSCLE / JOINT / BONE
Pain, weakness, numbness in:
____Arms ____Hips
____Back ____Legs
____Feet ____Neck
____Shoulders ____Hands

GENITO-URINARY
____Blood in urine
____Frequent urination
____Lack of bladder control
____Painful urination

GASTROINTESTINAL
____Appetite poor
____Bowel changes
____Constipation
____Diarrhea
____Excessive hunger/thirst
____Heat/Cold intolerance
____Hemorrhoids
____Heartburn
____Nausea/Vomiting
____Rectal bleeding
____Stomach pain

CARDIOVASCULAR
____Chest pain
____High blood Pressure
____Irregular heart beat
____Low blood pressure
____Poor circulation
____Rapid heart beat
____Shortness of breath with exercise
____Swelling of ankles
____Varicose veins

EYE, EAR, NOSE, THROAT
____Difficulty swallowing
____Eye/Ear problems
____Hoarseness
____Loss of hearing
____Nosebleeds
____Persistent cough
____Ringing in ears
____Sinus problems
____Sore throat

SKIN
____Bruise easily
____Hives
____Itching
____Change in moles
____Rash
____Skin problems
____Sore that won't heal
____Tick / Spider bites

RESPIRATORY
____Coughing up blood
____Shortness of breath
____Wheezing

MEN only
____Breast lump
____Erection difficulties
____Lump in testicles
____Sore on penis
____Other

WOMEN only
____Abnormal Pap Smears
____Bleeding between periods
____Breast lump
____Extreme menstrual pain
____Hot flashes
____Nipple discharge
____Painful intercourse
____Vaginal Discharge
____Other
Date of last menstrual period:_____
Date of last Pap smear:_____
Have you had a mammogram? ____yes ____no
Are you pregnant? ___yes___no
Number of children:_____
Number of sexual partners _____

CONDITIONS Check (x) conditions you currently have or have had in the past

_____AIDS
_____Alcoholism
_____Anemia
_____Anorexia
_____Appendicitis
_____Arthritis
_____Asthma
_____Bleeding Disorders
_____Breast Lump
_____Bronchitis
_____Bulimia
_____Cancer
_____Cataracts
_____Chemical dependency
_____Chicken Pox
_____Diabetes
_____Emphysema
_____Epilepsy
_____Glaucoma
_____Goiter
_____Gonorrhea
_____Gout
_____Heart disease
_____Hepatitis
_____Hernia
_____Herpes
_____High cholesterol
_____HIV Positive
_____Kidney disease
_____Liver disease
_____Measles
_____Migraine headaches
_____ Miscarriage
_____Mononucleosis
_____Multiple Sclerosis
_____Mumps
_____Pacemaker
_____Pneumonia
_____Polio
_____Prostate problems
_____Psychiatric care
_____Rheumatic Fever
_____Scarlet Fever
_____Stroke
_____Suicide attempt
_____Thyroid problems
_____Tonsillitis
_____Tuberculosis
_____Typhoid Fever
_____Ulcers
_____Vaginal Infections
_____Venereal Disease
___ _____
___ _____
___ _____
___ _____

MEDICATIONS List all medications you are currently taking	**ALLERGIES** To medications or substances

Pharmacy Name:

FAMILY HISTORY Fill in health information about your family

HEALTH HISTORY

(All information is strictly confidential)

Relation	Age	State of Health	Age at Death	Cause of death
Mother				
Father				
Brother				
Sister				

Check if your blood relatives had any of the following:		
X	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart disease, strokes	
	High blood pressure	
	Kidney disease	
	Tuberculosis	
	Other	

SURGERIES List all surgeries	Date	**IMMUNIZATIONS**	Date of most recent
		Flu shot	
		Pneumonia	
		Tetanus	

HEALTH HABITS Check which substances you use and describe how much you use		
Substance	**X**	Frequency
Alcohol		
Caffeine		
Drugs		
Tobacco		
Other		

OCCUPATIONAL CONCERNS Check if your work exposes you to any of the following		
	X	
Hazardous Substances		
Heavy Lifting		
Stress		
Other:		

Do you have spiritual beliefs? _____yes _____no Religious preference: _____

Have you ever had a blood transfusion? _____yes _____no

If yes, please give approximate dates:_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member(s) of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date