

# Community Health Center of the Black Hills, Inc.

Rapid City, SD 57701

(605) 721-8939 FAX (605) 721-8998

## Adult Health History (Ages 18+)

Today's Date: \_\_\_\_\_

<b>NAME:</b>	<b>DATE OF BIRTH:</b>
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### Past Medical History: Check conditions you have or have had in the past

<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Heart Attack When: _____	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hyperlipidemia (High Cholesterol)
<input type="checkbox"/> COPD	<input type="checkbox"/> Asthma	<input type="checkbox"/> Other lung disease Specify: _____	<input type="checkbox"/> Thyroid Disease Specify: _____
<input type="checkbox"/> Stroke When: _____	<input type="checkbox"/> Diabetes Type: _____	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Prostate Disease Specify: _____
<input type="checkbox"/> Kidney Disease Specify: _____	<input type="checkbox"/> Heartburn/Reflux Ulcers	<input type="checkbox"/> Hepatitis A, B or C Please circle which?	Other liver disease Specify: _____
<input type="checkbox"/> Substance Abuse Which: _____	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other Psych disease Which: _____
<input type="checkbox"/> Skin Condition Specify: _____	<input type="checkbox"/> Ear Condition Specify: _____	<input type="checkbox"/> Eye Disorder Specify: _____	<input type="checkbox"/> Arthritis Specify: _____
<input type="checkbox"/> Bleeding Disorder Specify: _____	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer Specify: _____
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Dementia/memory problems	<input type="checkbox"/> Blood Vessel Disease
<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Other Specify: _____

**Do you currently use tobacco?**  Yes  No

How many packs/cigarettes per day? \_\_\_\_\_

If you chew tobacco, how many cans per week? \_\_\_\_\_

**Do you drink alcohol?**  Yes  No

If yes, how many drinks per day? \_\_\_\_\_

**Please circle. Would you consider yourself a:**

Social Drinker      Heavy Drinker      Never drink alcohol      Former alcohol consumer

**Do you use any mind altering drugs?**  Yes  No **If yes, please circle.**

Marijuana      Cocaine      IV Drugs      Other: \_\_\_\_\_

**Do you drink coffee?**      Yes  No       **If yes, how many cups per day?** \_\_\_\_\_

**Do you drink energy drinks?**      Yes  No       **If yes, how many per day?** \_\_\_\_\_

**Have you had any prior surgeries? Yes  No**   
**If yes, please indicate which surgeries you had.**

<input type="checkbox"/> Eye Surgery Specify: _____	<input type="checkbox"/> Ear Tubes	<input type="checkbox"/> Thyroid Surgery	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Angioplasty/Stents	<input type="checkbox"/> Aortic Aneurysm Repair	<input type="checkbox"/> Open Heart Surgery/Bypass	<input type="checkbox"/> Pacemaker Placement
<input type="checkbox"/> Heart Surgery Specify: _____	<input type="checkbox"/> Lung Surgery Specify: _____	<input type="checkbox"/> Mastectomy	<input type="checkbox"/> Breast Biopsy
<input type="checkbox"/> Cholecystectomy (Gall bladder)	<input type="checkbox"/> Weight loss surgery Which: _____	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Gastric surgery Specify? _____
<input type="checkbox"/> Bladder Surgery Specify: _____	<input type="checkbox"/> Hernia Repair Specify: _____	<input type="checkbox"/> Back Surgery Specify: _____	<input type="checkbox"/> Carpal Tunnel Which side? _____
<input type="checkbox"/> Prostate Surgery Specify: _____	<input type="checkbox"/> C-section	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Ovary or Ovarian Cyst removal
<input type="checkbox"/> Cervix Treatment: LEEP/Cyro/Laser	<input type="checkbox"/> Laparoscopy	<input type="checkbox"/> Kidney Surgery: Specify: _____	<input type="checkbox"/> Lithotripsy
<input type="checkbox"/> Neurosurgery Specify: _____	<input type="checkbox"/> Orthopedic Surgery Specify: _____	<input type="checkbox"/> Other Specify: _____	<input type="checkbox"/> Other Specify: _____

**Is there any family history of any of the following? Please indicate who in immediate family had this: (mom, dad, brother, sister, son, daughter, maternal grandmother, paternal grandmother, maternal grandfather, paternal grandfather)**

<input type="checkbox"/> Alcoholism _____ _____ _____	<input type="checkbox"/> Mental Illness _____ _____ _____	<input type="checkbox"/> Diabetes _____ _____ _____	<input type="checkbox"/> Heart Attack _____ _____ _____	<input type="checkbox"/> Heart Disease _____ _____ _____	<input type="checkbox"/> High Blood Pressure _____ _____ _____
<input type="checkbox"/> Lung Disease _____ _____ _____	<input type="checkbox"/> Anemia _____ _____ _____	<input type="checkbox"/> Migraine Headaches _____ _____ _____	<input type="checkbox"/> Autoimmune Disease _____ _____ _____	<input type="checkbox"/> Kidney Disease _____ _____ _____	<input type="checkbox"/> Seizure Disorder _____ _____ _____
<input type="checkbox"/> Thyroid Disease _____ _____ _____	<input type="checkbox"/> Skin Cancer _____ _____ _____	<input type="checkbox"/> Brain Cancer _____ _____ _____	<input type="checkbox"/> Breast Cancer _____ _____ _____	<input type="checkbox"/> Cervical Cancer _____ _____ _____	<input type="checkbox"/> Colon Cancer _____ _____ _____
<input type="checkbox"/> Testicular Cancer _____ _____ _____	<input type="checkbox"/> Thyroid Cancer _____ _____ _____	<input type="checkbox"/> Lung Cancer _____ _____ _____	<input type="checkbox"/> Ovarian Cancer _____ _____ _____	<input type="checkbox"/> Prostate Cancer _____ _____ _____	<input type="checkbox"/> Other Cancer What kind: _____ _____ _____

Males and Females: Have you ever had an STD? If yes, please indicate which one(s)		
<input type="checkbox"/> Herpes	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Genital Warts
<input type="checkbox"/> HPV	<input type="checkbox"/> HIV	<input type="checkbox"/> Trichomoniasis
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Gonorrhea	
Females: Pregnancy History		
Have you ever been pregnant? If yes, how many times? (Gravida): _____ How many times have you given birth? (Para): _____ How many of these were full term? _____ How many of these were premature? _____ How many miscarriages have you had? _____ How many living children do you have? _____ How many abortions have you had? _____		
Sexuality:		
Are you Sexually Active? <input type="checkbox"/> Yes <input type="checkbox"/> No		
What is your Gender? <input type="checkbox"/> Female <input type="checkbox"/> Female-to-Male/Transgender Male <input type="checkbox"/> Male <input type="checkbox"/> Male-to-Female/Transgender Female <input type="checkbox"/> Other <input type="checkbox"/> Choose not to disclose		
What is your Sexual Orientation? <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know		
What is your current marital status?		
<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Legally Separated
<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Do not wish to say
What is your ethnicity?		
<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Non-Hispanic/Latino	<input type="checkbox"/> Do not wish to say
What is your race?		
<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander
<input type="checkbox"/> African American	<input type="checkbox"/> American Indian/Alaskan Native	<input type="checkbox"/> White
<input type="checkbox"/> More than one race	<input type="checkbox"/> Do not wish to say	
Work Status:		
<input type="checkbox"/> Employed	<input type="checkbox"/> Disabled	<input type="checkbox"/> Full Time Student
<input type="checkbox"/> Self-employed	<input type="checkbox"/> Retired	<input type="checkbox"/> Part Time Student
<input type="checkbox"/> Unemployed	<input type="checkbox"/> Migrant Worker	<input type="checkbox"/> Seasonal
Living Situation for Homeless Patients:		
<input type="checkbox"/> Homeless Shelter	<input type="checkbox"/> On the Street	
<input type="checkbox"/> Doubling Up	<input type="checkbox"/> Permanent Supportive Housing	
<input type="checkbox"/> Transitional Housing	<input type="checkbox"/> Other	

Are you a veteran?  Yes  No

Are you a disabled?  Yes  No

Do you have an important religious affiliation you wish us to know about:  Yes  No

Are you currently in a domestic abuse situation?  Yes  No