Vibrant Health
FAMILY CLINICS
River Falls – Ellsworth – Spring Valley

PATIENT HEALTH HISTORY

DATE COMPLETED

NAME | AGE | DOB

OCCUPATION | SIGNIFICANT OTHER

LIST ALL SPECIALIST AND PROVIDERS OF HEALTH CARE OUTSIDE OF OUR CLINIC (I.E. CARDIOLOGIST, NEUROLOGIST, UROLOGIST, PHARMACY, EYE DOCTOR, DENTIST, DIABETIC SUPPLIER ETC.)

I currently have Advanced Directives on file: ☐ Yes ☐ No

I would like information about Advanced Directives: ☐ Yes ☐ No

Please indicate if you have had any of the following in the past 3 months:

SYSTEM REVIEW:

General	YES	NO
Weight Loss	☐	☐
Weight Gain	☐	☐
Fever	☐	☐
Chills	☐	☐
Fatigue	☐	☐

Eyes	YES	NO
Wear Glasses	☐	☐
Wear Contacts	☐	☐
Vision Change	☐	☐
Last Eye Exam _____		
Eye Pain	☐	☐
Double Vision	☐	☐

Ears, Nose, Throat, Mouth	YES	NO
Ringing in Ears	☐	☐
Decreased Hearing	☐	☐
Ear Pain	☐	☐
Runny Nose	☐	☐
Sneezing	☐	☐
Sinus Infections	☐	☐
Nose Bleeds	☐	☐
Sore Throat	☐	☐
Last Dental Exam _____		
Voice Change	☐	☐

Respiratory	YES	NO
Cough	☐	☐
Short Of Breath	☐	☐
Wheezing	☐	☐
Asthma	☐	☐
Heavy Snoring/Sleep Apnea	☐	☐

Cardiovascular	YES	NO
Chest Pain	☐	☐
Heart Fluttering	☐	☐
Difficulty Lying Flat	☐	☐
High Blood Pressure	☐	☐
Swelling In Legs	☐	☐
Loss Of Consciousness	☐	☐
Fainting	☐	☐

Gastrointestinal	YES	NO
Nausea	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐
Heartburn	☐	☐
Blood In Stools	☐	☐
Black/tarry Stool	☐	☐
Constipation	☐	☐
Ulcer Disease	☐	☐

Urologic / Gynecologic	YES	NO
Pain With Urination	☐	☐
Frequent Urination	☐	☐
Increased Urge To Urinate	☐	☐
Difficulty Urinating	☐	☐
Up At Night Urinating	☐	☐
Losing Urine Control	☐	☐
Sexually Transmitted Diseases	☐	☐
Males:		
Difficulty With Erection	☐	☐
Females:		
Age Of First Menses _____		
Regular Menses	☐	☐
Menstrual Duration _____ Days		
Cycle Interval _____ Days		
Last Menses Started _____		
Abnormal Pap Smear	☐	☐

Hematologic	YES	NO
Anemia	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Prior Blood Transfusion	☐	☐
Swollen Lymph Nodes	☐	☐

Endocrine	YES	NO
Intolerance To Heat	☐	☐
Intolerance To Cold	☐	☐
Excessive Hunger	☐	☐
Excessive Thirst	☐	☐

Allergic / Immunologic	YES	NO
Seasonal Allergies	☐	☐
Recurrent Infections	☐	☐
Chicken Pox Disease	☐	☐
Chicken Pox Vaccine	☐	☐
Last Tetanus Booster _____		
Last Pneumonia Vaccine _____		

Musculoskeletal	YES	NO
Joint Pain	☐	☐
Back Pain	☐	☐
Muscle Pain	☐	☐
Recent Injuries / Falls	☐	☐

Skin	YES	NO
Changing Moles	☐	☐
Skin Cancer	☐	☐

Neurologic	YES	NO
Headaches	☐	☐
Numbness / Tingling	☐	☐
Memory Changes	☐	☐

Social / Family	YES	NO
History Of Abuse	☐	☐

CONTINUES ON REVERSE

☐ **Check here if your health history hasn't changed since your last visit.**

Present Concerns: _____

Current Medical Conditions: _____

Previous Hospitalizations: _____

Previous Surgeries: _____

Allergies: _____

Current Medications: _____

OBSTETRIC HISTORY: (Fill in as appropriate)

Pregnancy Date(s)	Outcome (i.e. Vaginal Birth)

SEXUAL HISTORY: (Circle answers and fill in as appropriate)

Are you sexually active? YES NO NOT CURRENTLY

Sexual Partners: MALE(S) FEMALE(S) BOTH

Method of Contraception: _____

HABITS: (Circle answers and fill in as appropriate)

Tobacco? YES QUIT NEVER

E Cigarettes YES NO

SMOKE CHEW SNUFF

Amount Per Day _____

Years Spent _____

Alcohol? YES QUIT NEVER

Times per week _____

Amount per time _____

Ever felt like you ought to cut down?	YES NO
Have people annoyed you by criticizing your drinking?	YES NO
Have you felt guilty about your drinking?	YES NO
Have you ever had an 'eye-opener' morning drink?	YES NO

Other Drugs? YES QUIT NEVER

(i.e. Marijuana) Which drugs? _____

Do you exercise regularly? YES NO

Which exercises? _____

How many times per week? _____

Do you follow a special diet? YES NO

Know your cholesterol levels? YES NO

Total _____ HDL _____ LDL _____ Triglyceride _____

Wear seat belts?	YES	NO	SOME
Wear a bike helmet?	YES	NO	SOME
Have a smoke detector?	YES	NO	
Carbon monoxide detector?	YES	NO	
Adult / infant CPR training?	YES	NO	
If you own a gun, is it secured?	YES	NO	N / A
(Women) Self Breast Exam?	YES	NO	
(Women) Screening Mammogram?	YES	NO	
(Men) Self Testicular Exam?	YES	NO	

FAMILY: (Circle answers and fill in as appropriate)

	LIVING	AGE	HEALTH CONDITIONS
MOTHER _____	Y N	_____	_____
FATHER _____	Y N	_____	_____
SIBLINGS			
1. M_____ F _____	Y N	_____	_____
2. M_____ F _____	Y N	_____	_____
3. M_____ F _____	Y N	_____	_____
4. M_____ F _____	Y N	_____	_____
5. M_____ F _____	Y N	_____	_____
6. M_____ F _____	Y N	_____	_____
CHILDREN (List names of children)			
1_____	Y N	_____	_____
2_____	Y N	_____	_____
3_____	Y N	_____	_____
4_____	Y N	_____	_____
5_____	Y N	_____	_____