

PACIFIC NORTHWEST PRIMARY CARE
Health Appraisal Form

PLEASE PRINT

Name: _____
 Last First Middle

Today's Date _____

Date of Birth: _____ (age) ____

Past Medical History

Surgeries/Dates

Home Phone: _____

Type of Work: _____

Marital Status: _____

Highest Education: _____

Previous Health Provider: _____

Medical Problems/Hospitalizations/ Major Illness/Injuries

Immunization History/Date Done

Tetanus: _____

TB Skin Test: _____ Results: _____

Influenza Vaccine: _____ Measles _____

Pneumonia Vaccine: _____

Hepatitis B Series: _____

Hepatitis A Series: _____

DRUG ALLERGIES

Family History Age Health Status or Cause of Death

Father		
Mother		
Siblings		
Children		

List Any Relatives With the Following:

Diabetes _____

Heart Problems _____

Heart Attack _____

High Blood Pressure _____

High Cholesterol _____

Cancer _____

Obesity _____

Depression/ Mental Illness _____

Thyroid Disorder _____

Smoker No Yes Age Started _____ Pack Per Day _____

Alcohol No Yes Type _____ Amount _____

Caffeine Use Types _____ Amount/Day _____

Quit Y N How Long _____

Any DUI Y N Any Alcohol Concerns Y N

Activity Level (check one or more boxes)

- Sedentary with little exercise
- Mild exercise with job, house or recreation (climb stairs, walk over 3 blocks, golf, bowl, etc.)
- Occasional vigorous activity with work or recreation
- Regular Vigorous exercise program or hard work

COMPLETE REVERSE

Circle if you have had of the following symptoms to an unusual or significant degree

Vision problems glaucoma wear glasses

Hearing problems right_____ left_____ chronic earaches ear tubes

Sinus problems frequent colds hay fever nose bleeds

Cough wheezing asthma bronchitis TB _____ pneumonia shortness of breath COPD

Dizziness fainting seizures headaches numbness

Chest pain heart murmur racing heart irregular heartbeat high blood pressure high cholesterol or triglycerides

Arthritis back pain joint pain/swelling muscle cramps ankle swelling fluid retention

Varicose veins phlebitis calf pain with walking

Diarrhea constipation heartburn reflux irritable bowel

Diabetes low blood sugar high blood sugar thyroid problems autoimmune disorder_____

Kidney trouble frequent urinary infections difficulty urinating sugar in urine blood in urine prostate trouble hernia

Infertility impotence or sexual dysfunction irregular menses polycystic ovaries

Sleep disorder snoring difficulty concentrating memory problems depression anxiety suicidal thoughts

Name of specialist involved in your care:

OB/GYN_____

Cardiologist_____

Pulmonary_____

Rheumatologist_____

Neurologist_____

Endocrinologist_____

Orthopedist_____

Naturopath_____

Other_____

Men Over 45 Last PSA checked _____

Women Only

Age at first Menstruation_____ Menstrual Problems_____

Date of last PAP_____ Any history of abnormal PAP: Y N HPV: Y N

Date of last mammogram_____ Where was it done?_____

Number of pregnancies_____ Number of Live Births_____ Age at first full term pregnancy_____

Birth Control Method_____ Do you do self breast exams? Never Occasionally Monthly

Hysterectomy_____ Ovaries present? Y N Hormone Type/Dose_____

Naturopathic or OTC Women's Support Meds:_____