VDH CONFIDENTIAL HEALTH HISTORY

DATE :_____

SECTION 1. CHECK BELOW IF YOU OR ANY FAMILY MEMBER HAVE THESE:

	YOU	FAMILY		YOU	FAMILY	OFFICE USE ONLY
1.Allergies (include hay fever)			18. Genetic Diseases			
2.Anemia /sickle cell or trait			19.Heart Problems			
3.Asthma or bronchitis			20. Hepatitis or liver disease			
4.Arthritis			21. High blood pressure			
5.Blood clots (legs or lungs)			22. Lead poisoning			
6.Blood disease or bleeding			23. Learning problems			
7.Bladder/Kidney problems			24. Mental illness/Depression			
8.Birth Defects/Retardation			25. Migraine headache			
9.Bone problems			26. Muscle/Joint problems			
10.Cancer			27. Skin problems			
11.Deafness/Ear problems/Tubes			28. Stroke			
12.Dental Problems			29. Suicide attempt			
13.Diabetes (sugar)			30. Thyroid problems			
14. Eating of non-food items			31. Throat problems			
15.Epilepsy/Seizures			32. Tuberculosis/other lung problem			
16.Feeding Problems/Special Diet			33. Vision Eye problem			
17.Gall bladder/Bowel problems			34. Other_____			

Have you ever been hospitalized? YES ____ NO _____ If YES; List dates and why
_____
_____

Your family doctor: _____ If you are on any medications, please list: _____

Are your immunizations up-to-date? YES ____ NO ____ Have you ever been hit, hurt, shoved, or sexually abused ? YES ____ NO ____

Check any of these that you now use, or that you have ever used: cigarettes/tobacco products ___, over-the-counter medicines____, alcohol/beer/wine/liquor ____, amphetamines/diet pills/speed ____, steroids_____, marijuana/hashish____, cocaine/crack ____, sedatives/tranquilizers ____, narcotics ____, drugs that you inhale ____, drugs that make you see things ____ , drugs that you inject _____.

Country of Birth _____ Current Occupation/School _____

Is transportation a problem for you? YES ____ NO _____

Do you live in house ___ apartment____ mobile home____ motel____ shelter ___ other _____? Number of persons living in household: _____

What type of heat do you have? _____ Home has: Refrigerator ____Stove____Running Water____Indoor plumbing____

Water Source is: well____ public ____ other_____ Does anyone in the household smoke? YES____ NO ____

Is there a smoke alarm in the home? YES _____ NO _____

Initial and follow-up review

DATE	NOTE:	INITIALS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NAME, ID # (LABEL)

Form 03-2 (Revised)

SECTION 2. ADULT FEMALES ONLY: PLEASE COMPLETE THE INFORMATION BELOW.

	Office Use Only		Office Use Only
At what age did your period start? _____ How often do you have a period? _____ How long do periods last? _____ Is flow low or heavy? _____ Do you ever miss a period? YES ___ NO___ Do you have cramps_____ swelling _____ mood swings _____ At what age did you begin having sex? _____ Have you ever had a problem with a PAP smear? YES ____ NO ____ How many sex partners have you had? NONE ____ ONE ____ MORE THAN ONE _____ Do any of your partners have a history of Infecting Drug Use ___ Multiple Partners ___ Same Sex Partners ___ Sexually Transmitted Disease or HIV ____		Circle each birth control method below that you have ever used: Condoms Foam Sponge Film Patch Ring IUD Cream Suppositories Diaphragm Cap Pill Shots (Depo-Provera) Norplant (Lunelle) Rhythm Withdrawal Current Method _____ Method Desired _____	

CHECK ANY OF THE CONDITIONS BELOW YOU HAVE EXPERIENCED:

		Office Use Only			Office Use Only
Pelvic Infections			High Blood Pressure in Pregnancy		
Female problems			Diabetes in Pregnancy		
Cysts/Tumors			Toxemia		
Breast disease			Twins or history in family		
Urinary infection			Complications of anesthesia		
Sexually Transmitted Disease			Blood Transfusions		
Premature Labor			Other_____		

HISTORY OF PREVIOUS PREGNANCIES: LEAVE BLANK IF NEVER PREGNANT

DATE	Previous Pregnancies Result: Circle one answer	Weeks Carried	Type of Delivery Circle one answer:	Birth Weight	Sex	Complications
	Abortion Live Birth Miscarriage Born dead		Vaginal C-section			
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NAME, ID # (LABEL)