District Four Patient Self-History Form

Patient Label Here:

Are You allergic to any Medications?
Y or N
If yes, which medications?

_____

_____

*** If you are unsure of any question, leave blank and ask the nurse for help.**

Medical History:

Circle those that apply, **Y** for **yes** or **N** for **no.**	You	Family	Nursing Comments:
Lupus	Y or N	Y or N	
Seizures or Stroke	Y or N	Y or N	
Sickle Cell Anemia or Trait	Y or N	Y or N	
Blood Clots in legs or lungs	Y or N	Y or N	
Heart Disease/Defect or Murmur	Y or N	Y or N	
Bleeding Disorder/Hemophilia	Y or N	Y or N	
High Blood Pressure	Y or N	Y or N	
High Cholesterol	Y or N	Y or N	
Asthma or Chronic Bronchitis	Y or N	Y or N	
Tuberculosis	Y or N	Y or N	
Liver Disease/Hepatitis	Y or N	Y or N	
Gallbladder Disease/Gallstones	Y or N	Y or N	
Stomach Problems/Ulcers	Y or N	Y or N	
Bowel Problems	Y or N	Y or N	
Kidney/Bladder Problems	Y or N	Y or N	
Osteoporosis	Y or N	Y or N	
Cancer	Y or N	Y or N	
Diabetes/Sugar Problems	Y or N	Y or N	
Scoliosis	Y or N		
Severe headaches/migraines	Y or N		
Skin rashes, sores or moles	Y or N		
Tattoos or Piercing	Y or N		
Anemia (low blood/ low iron)	Y or N		
Varicose Veins	Y or N		
Depression/Anxiety/Eating Disorders	Y or N		
Bi-polar Disorder/Schizophrenia	Y or N		
Drink Alcohol	Y or N		
Smokes/Chews/Dips Tobacco	Y or N		
Use Street Drugs	Y or N		
Diet Supplements/Herbal Medications	Y or N		

Have you ever had a major illness? Please explain:

_____

Have you ever been in the hospital? If so why:

_____

Have you ever had any type of surgery?

_____

List all medications you are taking:

_____

Tuberculosis Risk Assessment Questionnaire:

Is the child a close contact of a person with infectious TB? Y or N
Does the child have HIV infection or is he/she considered at risk for HIV infection? Y or N
Is the child foreign born (especially Asian, African, Latino) a refugee or immigrant? Y or N
Is the child in contact with an incarcerated person or a person was incarcerated in the past 5 years? Y or N
Does the child have a medical condition or treatment of a medical condition which suppresses the immune system? Y or N
Does the child live in a community in which it has been established that a high risk exists for TB? Y or N
Does the child have a history of travel or contact with an individual who traveled to endemic countries? Y or N

D4 8/2008

WOMEN ONLY:

Menstrual/ Gynecological History

What age did your menstrual periods begin? _____
When did your last period start? _____
How many days did it last? _____
Was it normal? Yes ____ No ____ Explain _____
How often do you have your periods? _____
Any problems? _____
Do you douche? Yes _____ No _____
Do you have a vaginal discharge/odor? Yes _____ No _____
Do you examine your breasts? Yes _____ No _____
If yes how often? _____
Any Breast problems? _____
Have you ever had a pelvic exam? Yes _____ No _____
If yes, date of last pelvic exam? _____
Date of your last Pap Smear? _____
Have you ever had an Abnormal Pap? Yes _____ No _____
Have you ever had a Mammogram? Yes _____ No _____
If yes, date of last Mammogram? _____

SEXUAL & CONTRACEPTIVE HISTORY:

Age at first intercourse? _____
Date of last intercourse? _____
Number of current partners? _____
How many sexual partners have you had? _____
Do you use condoms every time you have sex? Yes _____ No _____
Do you have sex with:
Men Only: _____ Women Only: _____ Both Men & Women: _____
Do you have pain or bleeding with sex? Yes _____ No _____
Do you inject any drugs? Yes _____ No _____
Do you or your partner have HIV or AIDS? Yes _____ No _____
Check the ways you have sex:
Vaginal _____ Oral _____ Anal _____
Have you had recent chills or fever? Yes _____ No _____
Have you or your partner ever had a sexually transmitted
Disease ? If yes, please circle which STD(s)?
(Gonorrhea, Chlamydia, Syphilis, Herpes, HPV, Other)?
What do you use for birth control?
Pills ____ Depo _____ Foam/Gel ____ Diaphragm _____
IUD _____ Patch _____ Condoms _____ Abstain_____
Withdrawal/Pull Out _____ None _____
Are you satisfied with the method? Yes ____ No _____
If no, what method(s) do you wish? _____
Do you or your partner want to become pregnant? Yes ___ No ____
If yes, when? _____

OBSTETRICAL HISTORY:

Have you ever been pregnant? Yes _____ No _____
If yes, how many times? _____
How many were:
Full term? _____ Premature? _____ Stillborn? _____
How many times did you have:
A Miscarriage? _____ An Abortion? _____
Did any babies weigh less than 5 1/2 lbs. at birth?
Yes _____ No _____
Did any babies weigh more than 9 lbs. at birth?
Yes _____ No _____
Did you breast or bottle feed your baby? _____
Are you breast feeding now? Yes _____ No _____
Did your mother take DES (diethylstilbestrol) when
she was pregnant with you? Yes _____ No _____
Did you have any problems with any
pregnancies? Yes _____ No _____
Have you had chickenpox or the vaccine Yes__ No__

MEN ONLY:

Have you been circumcised? Yes _____ No _____
Do you have any problems with testicles or scrotum
(Lumps, Pain, Swelling)? Yes _____ No _____
Do you perform testicular self-exams?
Yes _____ No _____
Have you ever been involved in a pregnancy or
fathered a child? Yes _____ No _____

RELATIONSHIPS:

Have you ever been hit, kicked, shoved, or had things
thrown at you by your partner? Yes _____ No _____
Have you ever been forced by anyone to have
intercourse or any form of sexual contact against your
will (when you have said or wanted to say "NO")
Yes _____ No _____
Have you or your children ever been afraid /threatened
by your partner/boyfriend ? Yes _____ No _____
Is there any close friend or family member that you can
talk to about sex, or other sensitive matter?
Yes _____ No _____
If yes, whom? _____
Do you ever feel like hurting yourself? ____Yes___No

PROVIDER/NURSE COMMENTS ONLY:

Client's Signature/ Legal Guardian: _____ Date: _____

Interpreted By: _____ Date: _____

Reviewed By: _____ Date: _____

Confidential Client (CIRCLE) Yes No