Grand Valley Primary Care
Community HOSPITAL

603 28 1/4 Road
Grand Junction, CO 81506
(970) 263-2600

Health History Sheet

Patient: _____ **DOB:** _____ **Age:** _____ **Gender:** M / F

Please mark any symptoms you are experiencing that are <u>related to your complaint today</u>:

Allergic/ Immunologic	Ears/Nose/Mouth/Throat	Genitourinary	Men Only
☐ Frequent Sneezing	☐ Bleeding Gums	☐ Pain with Urinating	☐ Pain/Lump in Testicle
☐ Hives	☐ Difficulty Hearing	☐ Blood in Urine	☐ Penile Itching, Burning or Discharge
☐ Itching	☐ Dizziness	☐ Difficulty Urinating	
☐ Runny Nose	☐ Dry Mouth	☐ Incomplete Emptying	☐ Problems Stopping or Starting Urine Stream
☐ Sinus Pressure	☐ Ear Pain	☐ Urinary Frequency	
Cardiovascular	☐ Frequent Infections	☐ Loss of Urinary Control	☐ Waking to Urinate at Night
☐ Chest Pressure/Pain	☐ Frequent Nosebleeds	**Hematologic / Lymphatic**	
☐ Chest Pain on Exertion	☐ Hoarseness	☐ Easy Bruising / Bleeding	☐ Sexual Problems / Concerns
☐ Irregular Heart Beats	☐ Mouth Breathing	☐ Swollen Glands	
☐ Lightheaded	☐ Mouth Ulcers	**Integumentary (Skin)**	☐ History of Sexually Transmitted Diseases
☐ Swelling (Edema)	☐ Nose/Sinus Problems	☐ Changes in Moles	
☐ Shortness of Breath When Lying Down	☐ Ringing in Ears	☐ Dry Skin	**Women Only**
	Endocrine	☐ Eczema	☐ Bleeding Between Periods
☐ Shortness of Breath When Walking	☐ Increased Thirst / Urination	☐ Growth / Lesions	
		☐ Itching	☐ Heavy Periods
Constitutional	☐ Heat/Cold Intolerance	☐ Jaundice (Yellow Skin or Eyes)	☐ Extreme Menstrual Pain
☐ Exercise Intolerance	**Gastrointestinal**		☐ Vaginal Itching, Burning or Discharge
☐ Fatigue	☐ Abdominal Pain	☐ Rash	
☐ Fever	☐ Black / Tarry Stool	**Respiratory**	☐ Waking to Urinate at Night
☐ Weight Gain (___lbs)	☐ Blood in Stool	☐ Cough	
☐ Weight Loss (___lbs)	☐ Change in Appetite	☐ Coughing Up Blood	☐ Hot Flashes
☐ Travel Within 10 Days Where:	☐ Frequent Indigestion	☐ Shortness of Breath	☐ Breast Lump
	☐ Hemorrhoids	☐ Sleep Apnea	☐ Breast Pain
Eyes	☐ Trouble Swallowing	☐ Snoring	☐ Nipple Discharge
☐ Dry Eyes	☐ Vomiting	☐ Wheezing	☐ No Periods
☐ Eye Irritation	☐ Constipation	☐ Difficulty Breathing	☐ Painful Intercourse
☐ Vision Changes	☐ Diarrhea	**Neurological**	☐ History of Sexually Transmitted Diseases
Psychiatric	☐ Nausea	☐ Dizziness	
☐ Anxiety / Stress	**Musculoskeletal**	☐ Fainting	☐
☐ Depression	☐ Back Pain	☐ Headaches / Migraines	☐
☐ Do Not Feel Safe in Relationship	☐ Joint Pain	☐ Memory Loss	☐
	☐ Muscle Aches	☐ Numbness	☐
☐ Mania	☐ Muscle Weakness	☐ Restless Legs	☐
☐ Sleep Problems	☐	☐ Seizures	☐
☐	☐	☐ Weakness	☐

Are you sexually active?: Yes No

Current Sexual Partner Is: Female Male Do you use condoms? Yes No

Method of Birth Control Used: _____

Women Only: Age of First Menstrual Period: _____ Date of Last Menstrual Period: _____

Age at Menopause: _____

Number of Pregnancies: _____ Live Births: _____

Miscarriages: _____ Abortions: _____

Number of Cesarean Sections: _____

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Health History, Page 1

Patient: _____

Please check any significant medical history in yourself or family members.

Condition	SELF	Father	Mother	Sibling	Mother's Parent(s)	Father's Parent(s)	Details
Alcoholism							
Anemia							
Anxiety							
Arthritis							
Asthma							
Birth Defects							
Blood Clots							
Bowel Problems							
Cancer - Type							
COPD							
Depression							
Diabetes							
Eye Disease							
Epilepsy / Seizures							
Heart Attack							
Heart Disease							
Heart Murmur							
Heartburn / Reflux							
High Blood Pressure							
High Cholesterol							
Kidney Disease							
Liver Disease							
Lung Disease							
Mental Illness Type:							
Migraines							
Stomach Ulcer							
Stroke							
Suicide / Suicide Attempt							
Thyroid Disease							
Tuberculosis							
Other:							

Past Surgical History:

Surgery	Reason	Year	Hospital

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Health History, Page 2

Patient: _____

Allergies: List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

Allergy	Reaction

Medications: Please list all of the medications you are taking, including over-the-counter and vitamins.

Medication	Strength	Frequency Taken

Health Maintenance:

Test	Date	Result (Please Circle)	
Complete Physical		Normal	Abnormal
Colonoscopy		Normal	Abnormal
Lipid (Cholesterol)		Normal	Abnormal
Eye Exam		Normal	Abnormal
Bone Density		Normal	Abnormal
PSA (Men 50-70 y.o.)		Normal	Abnormal
PAP Smear (Women)		Normal	Abnormal
Mammogram (Women)		Normal	Abnormal
Immunization	**Date**	**Immunization**	**Date**
Pneumonia Shot		Flu Shot	
Tetanus		Zostavax (Shingles)	

SOCIAL HISTORY:

Tobacco: _____ Current Every Day Smoker	_____ Current Some Days Smoker	#_____ Packs Per Day	
_____ Former Smoker	_____ Never a Smoker	_____ Use Chewing Tobacco	
Alcohol Use: No	Yes: How much per day?		
Drug Use: No	Yes: How much per day?		
Exercise: No	Yes: What kind of physical activity? How often do you exercise?		
Marital Status: ____ Single	____ Married	____ Separated	____ Divorced ____ Widowed
Level of School Completed:			

Assignment of Benefits: I hereby assign to **Grand Valley Primary Care** any insurance or other third party benefits available for health care services provided to me. I understand that Grand Valley Primary Care has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Grand Valley Primary Care, I agree to forward to the practice all health insurance and other third party payments I receive for services rendered to me immediately upon receipt.

Signature of Patient/Legal Guardian: _____ **Date:** _____