1. Last Name First Name MI

# CONFIDENTIAL

NC Department of Health and Human Services
Public Health Nursing and Professional Development

# PATIENT SELF-HISTORY FORM

*If you are unsure about any question, leave it blank And ask the nurse for help.*

2. Patient Number | | | | | | | | | -- | H

3. Date of Birth Month Day Year

4. Race 1. White 2. Black/African American
3. American Indian/Alaska Native 4. Asian
5. Native Hawaiian/Other Pacific Islander 6. Other
Ethnicity: Hispanic/Latino Origin? Yes No

5. Gender 1. Male 2. Female

6. County of Residence

## A. IMPORTANT INFORMATION (Please complete the following)

1. What is the reason for your visit today? ______________________________
2. Do you feel that you are in good health? Yes No
3. Emergency contact: ______________________________
4. May we contact you by mail? Yes No by phone? Yes No Your phone # is ______________
5. Are you seeing another doctor for any reason? Yes No
6. Do you have any allergies? Yes No If yes, what? ______________________________
7. Highest grade completed in school ______________________________

## B. List Serious Illness, Injuries, Hospitalizations, Operations:

______________________________

______________________________

## C. SELF & FAMILY MEDICAL HISTORY (Please put an X under YOU if you've had any of the following. Put an X under FAMILY if either a parent, grandparent, brother, sister or child of yours has had any of the following)

| YOU / FAMILY | | YOU / FAMILY | |
|---|---|---|---|
| 1. | Abuse (physical, sexual, verbal, or emotional) | 17. | Hernia |
| 2. | Anemia, Sickle Cell Disease or Trait, Blood disorder | 18. | High cholesterol, High blood pressure, Stroke |
| 3. | Anorexia, Bulimia, other eating disorders | 19. | HIV, AIDS |
| 4. | Arthritis, joint problems, back problems | 20. | Kidney or bladder problems, stones, dialysis |
| 5. | Asthma, Bronchitis, other breathing problems | 21. | Migraine or severe headaches |
| 6. | Birth defects, genetic problems, Cystic Fibrosis | 22. | Pain or numbness in arms or legs |
| 7. | Bleeding problems, blood clots in legs or lung, etc. | 23. | Physical disability |
| 8. | Bowel problems | 24. | Prostate problems |
| 9. | Breast lumps, discharge, tenderness, other problems | 25. | Rectal pain or bleeding, hemorrhoids or "piles" |
| 10. | Cancers, tumors (including cervical or uterine) | 26. | Rheumatic fever |
| 11. | Depression, anxiety, mental illness | 27. | Seizures ("fits") |
| 12. | Diabetes (sugar problems) | 28. | Stomach pain, cramps, ulcers |
| 13. | Eye problems, blurred vision or spots | 29. | Thoughts of harming self or others |
| 14. | Fainting, dizzy spells | 30. | Thyroid problems |
| 15. | Heart disease, heart problems, chest pain | 31. | Transfusions of blood or blood products |
| 16. | Hepatitis, liver problems, gallbladder problems | 32. | Tuberculosis |

**Provider/Nurse Comments ONLY:**

## D. Infectious Diseases (Please put an (X) by all that you have had)

1. Measles
2. Mumps
3. Rubella
4. Tetanus
5. Whooping Cough
6. Chicken Pox
7. Meningitis
8. Hepatitis A or B
9. Scarlet Fever
10. Rheumatic Fever
11. Any Sexually Transmitted Diseases
12. Other: ______________________________

## E. Vaccine History

| E. Vaccine History | Date | Vaccine | Date | Other Vaccines | Date |
|---|---|---|---|---|---|
| Tetanus shot (Td) | ________ | Chicken Pox | ________ | ________ | ________ |
| Measles shot (MMR) | ________ | Hepatitis B series | ________ | ________ | ________ |
| Influenza (Flu) | ________ | Pneumonia | ________ | ________ | ________ |

Patient Name, #, or DOB
or
Attach Patient Label Here

**F. Do You:**

| | | | |
|---|---|---|---|
| 1. Smoke or use smokeless tobacco | Yes | No | If yes, how much? ________ How long?_______________ |
| 2. Drink alcohol | Yes | No | If yes, how much? ________ How long?_______________ |
| 3. Take street drugs | Yes | No | If yes, what? ____________ How long?_______________ |
| 4. Take vitamins with folic acid | Yes | No | |
| 5. Take diet or herbal supplements | Yes | No | If yes, what? ________________________________ |
| 6. Take any medications (prescription or over the counter) | Yes | No | If yes, what?________________________________ |

**BOTH MEN AND WOMEN:**
**G. APPETITE/DIETARY/EXERCISE/SAFETY INFORMATION**
**Do You**:

1. Eat 5 fruits and vegetables a day? Yes No
2. Eat fewer than 2 meals a day? Yes No
3. Have trouble getting food? Yes No
4. Want to eat non-food items like dirt, clay, starch? Yes No
5. Exercise regularly (walk, swim, bike or other activity 30 minutes 3X/week)? Yes No
6. Have contact with chemicals/other hazards? Yes No
7. Use seatbelt while driving/riding in car? Yes No
8. Notice a weight change of more than 10 lbs? Yes No
9. Live in a safe place? Yes No
10. Have smoke detectors at home? Yes No
11. Have exposure to second hand smoke? Yes No
12. Have problems with transportation? Yes

**H. SEXUAL & CONTRACEPTIVE HISTORY**

1. Age at first intercourse? ___________
2. Date of last intercourse? ________________
3. Number of partners in past 6 months? ______
4. How many sexual partners have you had? _______
5. Do you use condoms every time you have sex? Yes No
6. Do you have sex with:
   Men only Women only Both men and women
7. Do you have pain or bleeding with sex? Yes No
8. Do you inject any drugs? Yes No
9. Have you had an HIV test? Yes No
   If yes, when? ________________________
10. Do you want HIV testing today? Yes No
11. Does your partner use drugs? Yes No
12. Check the ways you have sex: vaginal oral anal
13. Have you had recent chills or fever? Yes No
14. Have you or your partner ever had a sexually transmitted disease (Gonorrhea, Chlamydia, Syphilis, Herpes, other)? Yes No
    (If yes, please circle which sexually transmitted disease)
15. What have you used for birth control in the past?
    Pills Depo Shots Foam/Gel Diaphragm IUD
    Condoms Withdrawal (Pull out) Abstain Other
    None
16. What are you using now? ___________________________________
17. Are you satisfied with method? Yes No
18. If no, what method do you wish? _____________________________
19. Do you or your partner want to become pregnant?

**WOMEN ONLY:**
**I. MENSTRUAL/GYNECOLOGICAL HISTORY**

1. What age did your menstrual periods begin? _______
2. When did your last period start? _________________
3. How many days did it last? ______________________
4. Was it normal? Yes No
5. How often do you have your periods? _____________
6. Any problems? ______________________________
7. Do you douche? Yes No
8. Do you have a vaginal discharge or odor? Yes No
9. Do you examine your breasts? Yes No
   If yes, how often? ___________________________
10. Have you ever had a pelvic exam? Yes No
    If yes, date of last pelvic exam

**J. OBSTETRICAL HISTORY**

1. Have you ever been pregnant? Yes No
   If yes, how many times? _______________
2. How many were:
   Full term? ____ Premature? ____ Stillborn? ____
3. How many times did you have:
   A miscarriage? ____ An abortion? ____
4. Did any babies weigh less than 5½ lbs. at birth? Yes No
5. Did any babies weigh more than 9 lbs at birth? Yes No
6. Are you breast feeding now? Yes No
7. Did your mother take DES (Diethylstilbestrol) when she was pregnant with you? Yes No
8. Did you have a positive Group B Strep test with a previous pregnancy? Yes No
9. Did you have any problems with any pregnancies? Yes No

Patient's Signature: ____________________ Signature of Interpreter (if used): ____________________ Date: __________

**Reviewed By:** ____________________ (Nurse's signature) ________ (Date) ____________________ (Provider's signature) __________ (Date)

**PATIENT SELF-HISTORY FORM (DHHS 4060)**

| | |
|---|---|
| Purpose: | To expedite the collection of health history information. |
| Instructions: | This form is to be completed by the client and reviewed by the designated health care provider. The client is to follow the instructions that precede each section. The form is available in both English and Spanish. It is not a mandatory form and may be used at the discretion of the health department. |
| Disposition: | This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Archives and History. |