Columbiana Family Care Center

A Service of SALEM REGIONAL MEDICAL CENTER

116 Carriage Drive Columbiana, Ohio 44408

Health History Form

Patient's Name:_____

List any medical problems, prior hospitalizations and surgeries:

Medical Problems	Prior Hospitalizations & Year	Prior Surgeries & Year

List any medication allergies:

List all medications, including vitamins:

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency

Do you…

Smoke tobacco? ☐ Yes ☐No If yes, number of packs per day____	**Have a stressful job?** ☐ Yes ☐No Occupation_____	**Sexual preference:** ☐ Heterosexual ☐Homosexual ☐ Bisexual **Are you currently sexually active?** ☐ Yes ☐No
Use chewing tobacco? ☐ Yes ☐ No If yes, amount_____	**Have a stressful home life?** ☐ Yes ☐No	**Have concerns about your sexual function?** ☐ Yes ☐No
Use alcohol? ☐ Yes ☐No If yes, number of drinks per day____ Number of drinks per year____	**Have issues of domestic violence or abuse?** ☐ Yes ☐No	**Have a history of receiving a blood transfusion?** ☐ Yes ☐No
Smoke marijuana? ☐ Yes ☐No	**Exercise regularly?** ☐ Yes ☐No	**Have a history of sexually transmitted disease?** ☐ Yes ☐No
Use intravenous drugs now or in the past? ☐ Yes ☐No	**Eat a low fat diet?** ☐ Yes ☐No	**Number of sexual partners:** ☐ 0 ☐1-4 ☐5-8 ☐ 4 ☐ >8
Use other types of drugs? ☐ Yes ☐No If yes, list type_____	**Wear a seat belt?** ☐ Yes ☐No **Use a bicycle helmet?** ☐ Yes ☐No	**Suffer from depression?** ☐ Yes ☐No **Anxiety?** ☐ Yes ☐No

(continued on back…)

Health history (continued…)

Patient's Name:_____

Family history – List medical conditions:

Father	Mother	Siblings	Grandparents	Aunts, Uncles, Cousins

Women:

# of pregnancies____	Date of last menstrual period_____	Date of last pap test _____	Do you have a history of sexual abuse? ☐ Yes ☐No
# of births____ # of C-sections____	Are your periods regular? ☐ Yes ☐No	Abnormal pap test? ☐ Yes ☐No	Do you use birth control? ☐ Yes ☐No If yes, type:_____
# of miscarriages____	Is your menstrual flow heavy? ☐ Yes ☐No	Date of last mammogram _____	Do you have pain with intercourse? ☐ Yes ☐No Difficulty with orgasm? ☐ Yes ☐No
# of terminations____	Is your menstrual flow painful? ☐ Yes ☐No	Do you have nipple discharge? ☐ Yes ☐No	Do you have urinary incontinence? ☐ Yes ☐No

Men:

Do you have urinary hesitancy? ☐ Yes ☐No	Do you have penile discharge? ☐ Yes ☐No If yes, is the discharge regular? ☐ Yes ☐No	Do you have history of prostate problems? ☐ Yes ☐No
Do you have erectile dysfunction? ☐ Yes ☐No	Do you have a history of hernia? ☐ Yes ☐No	