OPTUM Care®

Health history

To help us give you the best possible care, please complete both sides of this form.

Medical history

Hospitalizations, surgery, serious injuries	Age/date

☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer ________________
☐ Diabetes -type _________
☐ Epilepsy
☐ Heart disease
☐ Hepatitis type ____________
☐ High blood pressure
☐ Lung disease
☐ Psychiatric/emotional
☐ Rheumatic fever
☐ Sexually transmitted disease
☐ Thyroid
Other: ____________________

Family history–circle **M** for male / **F** for female

Your family	Age	Age at death	Cause of death
Father			
Mother			
Siblings: M F			
M F			
M F			
M F			
M F			

Check if any family members have had any of the following:
Please write in the space, which family member(s).
☐ Asthma ________________________________
☐ Cancer–type? ____________________________
☐ Diabetes ________________________________
☐ Heart attack ______________________________
☐ High blood pressure _________________________
☐ High cholesterol ___________________________
☐ Stroke __________________________________
☐ Tuberculosis ______________________________
☐ Alcohol/drug abuse _________________________

Do you have any children with chronic health problems? ☐ Yes ☐ No–describe: ______________________

Please list any medical problems that seem to run in your family: ______________________________

Allergies (describe reaction): ☐ None known ☐ Latex ______________________________

Current medications–include prescriptions, over the counter, viatmins, diet pills, herbal remedies, dietary supplements

Medications	Dose	Frequency	Medications	Dose	Frequency

Last **immunizations** write in year if known	**Tetanus**	**Flu**	**Pneumonia**

Women only:
Last pap smear–date: ______________________ **Last mammogram**–date: __________________________
First menstrual period–age: _________________ **Last menstrual**–date: ____________________________
Last pap smear–date: ______________________ **Last mammogram**–date: __________________________
Birth control method: ☐ None ☐ Pills ☐ Depro-provera ☐ Other: ________________________________
Number of–pregnancies: _________ living children: _________ miscarriages/abortions: _________

Date: _______ / _______ / _______

Health history

Social history/lifestyle

Relationship status: ☐ Single ☐ Spouse/Partner ☐ Widowed

Education (last grade/degree completed): ________________ Your occupation: ____

Do you have advance directives (Living will)? ☐ Yes ☐ No

- Are you on a special diet? ☐ No ☐ Yes Please describe: ____
- Caffeine intake–number of cups of coffee/tea/cola per day: ____
- Do you exercise for more than 20 minutes at a time, 3 times or more days a week? ☐ No ☐ Yes–type: _______________
- Have you ever smoked? ☐ No ☐ Yes–year started: ______ ☐ smoke now–packs per day: ______ ☐ Quit–date: _________
- Do you use smokeless tobacco? ☐ No ☐ Yes
  If yes to tobaccos use, would you like help with quitting? ☐ No ☐ Maybe ☐ Yes
- Do you now or have you ever used drugs other than prescription or "over the counter'?
  ☐ No ☐ Yes–Type: _____________________ Frequency: _________________ Occasionally ☐ Regularly ☐
- How often do you drink anything containing alcohol? ☐ never (If you do not drink, skip the next 2 questions)
  1 ☐ less than monthly 2 ☐ monthly 3 ☐ weekly 4 ☐ 2-3 x a week 5 ☐ 4-6 x a week 6 ☐ daily
- How many drinks do you have on a typical day when you are drinking? (a mixed drink with double shots counts as 2 drinks)
  0 ☐ 1 drink 1 ☐ 2 drinks 2 ☐ 3 drinks 3 ☐ 4 drinks 4 ☐ 5-6 drinks 5 ☐ 7-9 drinks 6 ☐ 10 or more
- How often do you have 4 or more drinks on every occasion? (a mixed drink with double shots counts as 2 drinks)
  0 ☐ Never 1 ☐ Less than monthly 2 ☐ monthly 3 ☐ weekly 4 ☐ 2-3 x week 5 ☐ 4-6 x a week 6 ☐ daily
- Do you use seat belts regularly? ☐ Yes ☐ No
- Are you currently in a relationship/living situation where you are physically or emotionally hurt, threatened or made to feel afraid? ☐ No ☐ Prefer not to answer ☐ Yes ____

Review of systems– Please check below if you have problems with any of the following:

General health– ☐ Fatigue ☐ Fever ☐ Unintentional weight change– ☐ Loss ☐ Gain # of pounds: ______________		
☐ Eyes	☐ Digestion/bowels	☐ Skin
☐ Ears/nose/mouth/throat	☐ Kidneys/bladder	☐ Breasts
☐ Heart/circulation	☐ Reproductive system	☐ Mental or emotional
☐ Lungs/breathing	☐ Muscles/bones	☐ Other:

☐ I have no problems with any of the above.

Reasons for today's visit: ____

____

Are you presently experiencing pain? ☐ No ☐ Yes–please answer the following:

Location(s): ____________________________________Quality: ☐ Dull ☐ Sharp ☐ Throbbing Other:_____________________

Intensity (Scale: 0 = none, 10 = most severe: _______ How long have you had this pain? _________________________________

Are there any topics you wish to discuss today?

☐ Diet/nutrition	☐ Stress management	☐ Drug use	☐ Birth control	☐ Pain management
☐ Weight management	☐ Smoking	☐ Alcohol use	☐ Sexuality Other:	

How do you prefer to get health information? ☐ Verbal/discussion ☐ Written materials ☐ No preference

Is there anything that could interfere with your learning? ☐ No ☐ Yes–describe: ______________________________________

Phone number: _________________________________

____

	M , 65; **F** or ≥ 65 : 7

Reviewed by (provider signature): _________________________________

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