Family First Health Care Yale, PLLC

SELF ASSESSMENT

Name - _____

HABITS (PLEASE ESTIMATE HOW MUCH PER DAY)

Beer_____ Cigarettes _____ Wine _____ Cigars _____

Whiskey_____ Chewing Tobacco_____ Vodka _____ Pipe _____

Other Alcohol _____ Coffee/Tea _____ Marijuana/Other Drugs _____

Exercise regularly?_____

INDICATE WHETHER YOU HAVE HAD ANY OF THE FOLLOWING:

- ❒ Alcoholism
- ❒ Anemia
- ❒ Anorexia
- ❒ Arthritis
- ❒ Asthma
- ❒ Bleeding Disorder
- ❒ Breast Lump
- ❒ Bronchitis, Chronic
- ❒ Bulemia
- ❒ Cancer
- ❒ Cataracts
- ❒ Chemical Dependency
- ❒ Chicken Pox
- ❒ Depression
- ❒ Diabetes
- ❒ Emphysema
- ❒ Epilepsy
- ❒ Glaucoma
- ❒ Gout
- ❒ Heart Disease
- ❒ Hepatitis
- ❒ Hernia
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ HIV Positive/AIDS
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Measles
- ❒ Migraine Headache
- ❒ Mononucleosis
- ❒ Mumps
- ❒ Pacemaker
- ❒ Pneumonia
- ❒ Polio
- ❒ Prostate Problems
- ❒ Psychiatric Care
- ❒ Rheumatic Fever
- ❒ Scarlet Fever
- ❒ Stroke
- ❒ Suicide Attempt
- ❒ Thyroid Problem
- ❒ Tuberculosis
- ❒ Typhoid Fever
- ❒ Ulcers
- ❒ Vaginal Infection
- ❒ Other _____

Last Tetanus _____ Last Flu Shot _____ Last Pneumonia Vaccine _____ Last Cholesterol _____ Last Mammogram _____

FAMILY HISTORY: indicate if a family member has had any of the following:

- ❒ Allergies
- ❒ Anemia
- ❒ Bleeding Disorder
- ❒ Cancer (type)_____
- ❒ Diabetes
- ❒ Epilepsy/Seizures
- ❒ Glaucoma
- ❒ Heart Disease
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Kidney Disease
- ❒ Mental Illness
- ❒ Migraine
- ❒ Stroke
- ❒ Thyroid Disease
- ❒ Tuberculosis
- ❒ Other

FOR WOMEN ONLY

Are you pregnant?_____ Age when period started _____ Date of last pap smear _____

Periods are: ❒ Regular ❒ Irregular

❒ Heavy ❒ Light ❒ Average

❒ Painful ❒ Mild ❒ Average

Number of Preganacies _____ Miscarriages _____ Abortions _____

Premature Births _____ Twins _____ Living Children _____

HISTORY OF SEXUALLY TRANSMITTED DISEASES (Please check if you have had any of the following)

❒ Venereal Warts ❒ Chlamydia ❒ Gonorrhea ❒ Syphilis

❒ HIV/AIDS ❒ Herpes ❒ Trichomonas

SYMPTOM REVIEW Circle any of the following symptoms which have been a serious or frequent problem for you.

Headaches
Poor Eyesight
Wear glasses/contacts
Eye pain or itching
Frequent ear infections
Hearing problems

Sore in mouth
Bleeding gums
Growth in mouth
Hoarseness
Nose bleeds
Congested nose

Chronic cough
Coughing up blood
Wheezing
Shortness of breath
Irregular heartbeat
Chest pain
Swelling of feet
Passing out

Abdominal pain
Nausea/Vomiting
Trouble swallowing
Vomiting blood
Black or bloody stools
Chronic constipation
Anal pain
Jaundice
Heartburn

Pain with urination
Difficulty urinating
Leaking urine
Blood in urine
Kidney stones
Urinating too much

Muscle pain
Joint pain
Cold arms/legs
Leg pain when walking
Swollen joints
Chronic back pain

Skin rashes
Other skin conditions
Acne
Bleeding or bruising tendency

Dizziness
Seizures
Tremors
Paralysis
Weakness

Weight loss
Weight gain
Poor appetite
Hair loss
Fever
Trouble sleeping
Fatigue
Memory loss

Depression
Agitation
Anxiety
Loneliness
Anger
Violence
Thoughts of suicide
Family problems

Sexually active	Y	N
Homosexual	Y	N
Heterosexual	Y	N
Bisexual	Y	N

MEN ONLY
Prostate trouble
Penis discharge
Lump on testicle
Problems with sex life

WOMEN ONLY
Breast lump
Hot flashes
Vaginal discharge
Abnormal pap smear
Pelvic pain
Nipple discharge
Trouble getting pregnant
Problems with sex life

Allergies or adverse reactions to medications or food: _____

_____

Current Medications: _____

_____

Surgeries, hospitalizations or serious illnesses: _____

_____

PATIENT/LEGAL GUARDIAN SIGNATURE _____

DATE _____