# HEALTH HISTORY

PORT LAVACA CLINIC ASSOCIATES, P.A.
1200 N. VIRGINIA ST. PORT LAVACA, TEXAS 77979 361-552-6721

DATE:_____

Name: _____ Age: _____ Birth Date: ____/____/____
Last First MI Sex: Male Female

Highest Grade Completed _____

Place of Employment _____ How Long? _____ Occupation _____

Single Married Separated Divorced Widowed

| Others Who Live With You | Relationship | Age | Receive Care Here? |
|---|---|---|---|
| | | | yes no |
| | | | yes no |
| | | | yes no |
| | | | yes no |
| | | | yes no |

Do you have any special spiritual, religious, or cultural needs? No Yes Explain_____

ALLERGIES: Any allergies or reactions to any medications, X-ray dyes, foods, environmental or other substances? No Yes (please list)

1._____ 2._____ 3._____ 4._____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:

Please circle if you have had problems with or are presently complaining of any of the following:

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest Pain/discomfort
6. Shortness of Breath
7. Swollen Ankles
8. Palpitations
9. Lightheadedness
10. Stroke
11. High cholesterol
12. Fever, chills, sweats
13. Pneumonia
14. Persistent Cough
15. Tuberculosis (TB)
16. Asthma
17. Hayfever
18. Indigestion/ heartburn
19. Abdominal Discomfort
20. Change in appetite
21. Constipation or diarrhea
22. Unexplained Wt Gain/Loss
23. Blood in Stool
24. Ulcers
25. Hemorrhoids
26. Gallbladder Disease
27. Hepatitis or liver disease
28. Thyroid Disease
29. Seizures
30. Headaches
31. Incontinence
32. Kidney Diseases
33. Kidney Stones
34. Difficulty Urinating
35. Urine infections
36. Arthritis
37. Blood disorder
38. Sickle cell
39. Blood clots
40. Anemia
41. Anxiety
42. Depression
43. Skin Diseases
44. Hearing difficulty
45. Gout
46. Low Back Problems
47. Glasses or contacts
48. Glaucoma/cataracts

Any problems not listed above: _____

Are you on a special diet? No Yes Type: _____

Do you use any community resources? (i.e. Home Health, etc.) No Yes Which? _____

**FEMALE HEALTH HISTORY:**

Age of start of periods: _____ years old
Frequency: _____ Length of Period: _____ days
Pregnancies: _____
Births: _____ Miscarriages: _____
Method of Birth Control: _____

| | |
|---|---|
| Prolonged of Abnormal Bleeding | No Yes |
| Leakage of Urine | No Yes |
| Pelvic Pain | No Yes |
| Abnormal Discharge | No Yes |
| History of Abnormal Pap Smear | No Yes |
| Sexually transmitted disease | No Yes |

**MALE HEALTH HISTORY:**

| | |
|---|---|
| Testicular masses | No Yes |
| Discharge from the penis | No Yes |
| Sexually transmitted disease | No Yes |
| Problems with erections | No Yes |
| Difficulty urinating | No Yes |

Please turn OVER