

El Paso County Employee and Dependent Medical Clinic – Patient Health Survey

The answers on this form will help your provider understand your medical problems and concerns better. This form will become part of your chart. If you are uncomfortable with any question, you may leave it blank. Best estimates are fine if you are unable to remember specific details. **Thank You!**

Name _____ Age _____ Sex: M F (circle one)

How do you rate your present health? Excellent Good Fair Poor (circle one)

What about your health would you like to change? _____

What are your present health concerns?

**FAMILY HISTORY – Any family members with the following...
(specify who in the family had the problem)**

Cancer _____ Heart disease _____

High Blood Pressure _____ Stroke _____

Thyroid Disease _____ Diabetes _____

High Cholesterol _____ Mental Illness _____

Depression _____ Alcohol/Drug abuse _____

Tuberculosis _____ Arthritis _____

HISTORY OF PAST ILLNESSES – Have you had...

Childhood: Measles Mumps Chicken pox Rheumatic fever (Circle all that apply)

Adult: Asthma High blood pressure Cancer (Site _____) Diabetes Anemia

Gastritis/Ulcer Thyroid problems Liver problems Kidney problems Heart attack

Sexually Transmitted Disease Tuberculosis Abnormal heart rhythm Heart failure

Depression Suicide attempt

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Have you had a serious injury? When? _____

Have you ever been hospitalized? When? _____

Have you had surgery? When and for what? _____

Immunizations: when was your last:

Tetanus shot _____ Hepatitis B _____ Flu shot _____ Pneumovax _____

Allergies: _____

Medications: _____

SOCIAL HISTORY (Please circle all that apply)

Weight loss Weight gain Alcohol use (# of drinks each week) _____ Bike helmets

Seat belt use Tobacco use (amount per day) _____ Recreational drug use

Sexual preference _____ Exposure to chemicals Special diet

Exercise (type, duration, frequency) _____

Do you feel safe in your current relationships? YES NO (Circle one) If NO explain...

When was your last physical exam? _____ Last eye exam? _____

Females ONLY: When was your last: PAP smear _____ Mammogram _____

Pregnancies ____ Abortions/miscarriages ____ Birth control use _____

At what age did you start your period? Any concerns?

