Sana Medical Group

Initial Health Assessment History

Name:_____ Birth Date: _____ Age: _____ Gender: □F □M

Language preference: □English □Spanish □Other:_____ Reason for Visit: _____

Preventative History: (Mark Vaccinations Received)

Childhood Vaccinations: □Complete □Incomplete □Unvaccinated □Unsure/Unknown

Adolescent Vaccinations: □HPV □Meningococcal □TDAP

Adult Vaccinations: □Hepatitis B □Influenza □MMR □Pneumovax □Shingles □TDAP

Screening Exams: (18 yrs and above) (Mark Screenings Received)

□Breast Cancer Screening □Diabetes Control: Hemoglobin A1c □Osteoporosis (DEXA)

□Colorectal Cancer Screening □Diabetes Kidney Disease □Hypertension Controlled

□Cholesterol LDL Screening □Diabetic Eye Exam □Pap Smear:_____

□Rheumatoid Arthritis Screening □Glaucoma Screening □STD/Chlamydia Screen:_____

Family History:

Has anyone your family had trouble with the following? Include mother (M), father (F), brother (B), sister (S), grandmother (GM) and grandfather(GF)

	□No	□Yes	What/Who/Age		□No	□Yes	What/Who/Age
Cancer (type) _____	□	□	_____	Heart Disease (type) _____	□	□	_____
Depression	□	□	_____	High Blood Pressure	□	□	_____
Diabetes	□	□	_____	High Cholesterol	□	□	_____
Heart Attack	□	□	_____	Stroke/CVA	□	□	_____

Please list any other significant family history we should know about:_____

Medical History:

	N	Y		N	Y		N	Y		N	Y
Allergies	□	□	Diabetes	□	□	Gallbladder Disease	□	□	Shortness of Breath	□	□
Asthma/Lung Disease	□	□	Eating Disorder	□	□	Kidney Disease	□	□	Stomach/Bowel Dx	□	□
Anemia	□	□	Epilepsy/Seizures	□	□	Liver Disease	□	□	Stroke	□	□
Arthritis	□	□	Headaches/Migraines	□	□	Obesity	□	□	Syncope	□	□
Bladder Disease	□	□	Heart Disease	□	□	Palpitations	□	□	Thrombophlebitis	□	□
Breast Problems	□	□	Hernias	□	□	Pain	□	□	Thyroid Disease	□	□
Cancer (type)	□	□	High Blood Pressure	□	□	Rashes/ Skin	□	□	Tuberculosis	□	□
Chronic Pain (type)	□	□	High Cholesterol	□	□	Rectal Pain/Bleeding	□	□	Weight Loss	□	□
Depression/Anxiety	□	□	Infectious Disease	□	□	STD	□	□	_____	□	□

□Nonsmoker □Previous Smoker □E-Cigarettes □Cigarettes #Packs per Day_____ #Years Smoking_____

□Nondrinker □Previous Alcoholic □Alcoholic #Drinks per Day_____ #Days/Wk_____ #Years Drinking_____

□Not Drug User □Previous Drug User Drugs of Abuse?: □Cocaine □Marijuana □Methamphetamine □PCP

□IV Drugs (Heroin) □Designer Drugs (Ecstasy, LSD, Salts) □ Mushrooms/Peyote □Home Products: Glues/Sprays

Have been physically, sexually or verbally abused by your intimate partner: □No □Yes Have been sexually molested: □No □Yes

Do you regularly exercise: □No □Yes Trying to lose weight : □No □Yes Used weight loss medication?: □No □Yes

Surgical History:

Have you had surgery?: □No □Yes If yes, when and what type:_____

□Appendectomy □CABG □Cosmetic □Cholecystectomy □Coronary Stents □Hernia □Hysterectomy □Mastectomy

Sexual Health:

□Single □Married □Divorced □Partner # Sexual partners this year?:_____ Previous STDs : □No □Yes Infertility: □No □Yes

Birth control method: □Birth Control pills □Condoms □Depo-Provera □Foam/Jellies

□Hormonal Ring □IUDs □Patch □Withdrawal/Natural

Procedures: □Hysterectomy □Tubal ligation □Vasectomy

Mens Health:

□Circumcised □Discharge □Hematuria □Impotence □Inadequate Erection □Loss Libido

□Painful Erection □Penile Lesions □Premature Ejaculation □ Prostate /Flow □Scrotal Pain □Testicular Pain/Mass

Womens Health:

First menstrual period at age?: _____ 1st day of Last Menstrual Period:_____ Menopause?:_____

#Pregnancies:____ #Births:____#Abortions:____#Miscarriages:____#Ectopic____

C-Section#:____ Vaginal Birth#____ Complications:_____ Genetic Abnormalities:_____

Last Pap Smear:_____ Abnormal Pap smear?: □No □Yes Colposcopy?: □No □Yes Mammogram: □No □Yes Breast Exam: □No □Yes

□Breast Cancer □Breast Lumps □Bleeding □Discharge □Endometriosis □Irregular Periods

□Lesions □Missed Periods □Ovarian Cysts □Painful Sex □Uterine Fibroids □Vaginal Dryness

Social History:

Grade Completed: _____ Highest level of Education Years_____ Occupation: _____

Any Religious, Cultural, or Ethical beliefs we should be aware of?: _____

Home Environment: Lives with: □Family □Alone □Separated □Homeless #Children:_____

Family dynamics/problems: □Domestic Violence □Sexual Abuse □Other: _____

End-of-Life Planning: □Advanced Directive □Personal Will □Power of Attorney in Health Care □Conservator

Concerns for lack of financial resources in health care: □No □Yes Additional Information?: _____

HIPPA Communication Authorization

There are occasional family members, friends or others might be involved in her care. As a patient, you will want our staff to be able to communicate directly with them. In order to protect the privacy of her personal health information, please share with us the names of other individuals with whom we can discuss your care and share personal protected health information.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I have completed this form to the best of my knowledge:

Patient Name: _____ Signature: _____Date: _____

Nurse/MA Signature: _____ Date: _____

M.D./N.P. Signature: _____ Date: _____