

TUSCOLA COUNTY HEALTH DEPARTMENT

Phone: 989-673-8114

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www.tchd.us

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ANNUAL PATIENT VISIT

Date _____
Client I.D. # _____

PLEASE PRINT

Name _____ Birth Date _____ Age _____
Last First Middle

Maiden Name: _____ Marital Status: S M D Sep W

Address _____ City _____ State _____

Zip _____ County _____ Phone # _____

How may we contact you at the above address by? Phone Letter

May we leave a message by phone? Yes No

If needed, provide another form of contact _____

If contact by letter, can the envelope have the Health Department return address on it? Yes No

Home phone number _____ Work phone number _____ Or contact phone number _____

If you are under 18 years of age, do your parents know you are here? Yes No

Are you a student now? Yes No Grade you are currently in? _____

REASON FOR VISIT? _____

NEW INFORMATION SINCE YOUR LAST VISIT

PERSONAL/SOCIAL HISTORY				
	YES	NO	?	STAFF NOTES ONLY
Allergies (food, medications, latex)				
Do you have 3 servings of dairy products or take a calcium supplement daily?				
Do you use tobacco? Type _____ How much _____				
Do you use illegal drugs?				
Do you use alcohol? How much/how often _____				
MENSTRUAL/GYNECOLOGICAL HISTORY				
First day of your last period ____/____/____	Do you have a period every month? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Periods usually last how many days?	Age your first period began:			
Do you use <input type="checkbox"/> Pads <input type="checkbox"/> Tampons <input type="checkbox"/> Both	Date of your last pap smear/pelvic exam:			
Have you ever had sexual intercourse? <input type="checkbox"/> Yes <input type="checkbox"/> No	Monthly Breast Self Exam		<input type="checkbox"/> Yes <input type="checkbox"/> No	
How many partners have you had in the past year?	Age of first sexual activity?			
Have ever been sexually or physically mistreated by a family member or someone else? <input type="checkbox"/> Yes <input type="checkbox"/> No				
DO YOU HAVE ANY OF THE FOLLOWING?	YES	NO	?	STAFF NOTES ONLY
Unusual vaginal discharge/itching/odor/burning				
Infections in uterus/tubes/ovaries				
Chlamydia, gonorrhea, herpes, syphilis, HPV, etc.				
Pain or bleeding with intercourse				
Missed periods				
Severe menstrual cramps				
Abnormal pap smears				
PREGNANCY HISTORY				
Total number of pregnancies _____, still births _____, miscarriages _____, abortions _____, ectopic (tubal) _____				
Number of children born alive:	Are you planning to have more children? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you think you might be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you tried to become pregnant for more than 12 months without success? <input type="checkbox"/> Yes <input type="checkbox"/> No			

CONTRACEPTIVE HISTORY

	YES	NO
What method of birth control are you using now?		
Have you had any problems with the method you are now using?		
Do you want to continue with present birth control method?		
Does your form of birth control offer you any protection against sexually transmitted infections or AIDS?		
Consistent use of condoms?		
Are there any special concerns you have today?		

PARTNER HISTORY

Please check if your partner(s) has a history of any of these activities	YES	NO
Injectable drug use?		
Multiple partners?		
Bisexuality?		
History of STI's?		
History of HIV?		
Homosexuality		

FAMILY HISTORY

HAVE YOUR GRANDPARENTS, PARENTS, BROTHERS, OR SISTERS EVER HAD:	YES	NO	Relationship	STAFF NOTES ONLY
Early coronary artery disease (before age 50)				
High Blood Pressure				
Stroke				
Hyperlipidemia (elevated cholesterol)				
Diabetes				
Breast, ovarian, cervical, colon cancer				
Osteoporosis				
If you were born between 1940-70, did your mother take DES (a hormone to prevent miscarriage)				
Genetic problems				

PAST MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING?	YES	NO	?	STAFF NOTES ONLY
Are you being treated for a chronic illness, such as high blood pressure, diabetes, cardiac disease, obesity, kidney or respiratory problems? If so, please list:				
Are you taking any over the counter or prescription medications? If so, please list:				
Have you had any surgeries? If so, please list:				
Have you ever been hospitalized? If so, for what and when:				
Have you had a blood transfusion before 1984?				

REVIEW OF SYSTEMS

DO YOU HAVE ANY OF THE FOLLOWING?	YES	NO	?	STAFF NOTES ONLY
GENERAL HEALTH: (fatigue, weight gain/loss, fevers, recent illnesses)				
EYES: (visual problems, blurring)				
EARS/NOSE/THROAT: (hearing, sinus, oral lesions, difficulty swallowing)				
RESPIRATORY: (shortness of breath, cough, asthma, bronchitis, pneumonia, or bloody sputum)				
CARDIOVASCULAR: (high blood pressure, heart disease, murmurs, chest pains, elevated cholesterol)				
BLOOD DISORDERS: (anemia, blood clots, bleeding tendency, Sickle Cell Anemia, Factor V)				
GASTROINTESTINAL: (nausea/vomiting, ulcer, diarrhea/constipation, abdominal pain, hepatitis, mono, jaundice)				
URINARY: (urinary tract infection, kidney disease)				
MUSCULOSKELETAL: (arthritis, injuries, osteoporosis)				
ENDOCRINE: (thyroid disease, diabetes, abnormal hair growth, appetite changes)				
SKIN/BREAST: (rash, change in mole, skin lesion, nipple retracting/discharge, breast pain, breast mass/lump/thickness)				
NEUROLOGICAL: (seizure disorder, stroke, severe pain/numbness in arms or legs, headaches (migraine in nature)) If you have headaches: *with nausea and/or vomiting? *with unusual sensitivity/intolerance to sound or light? *see flashing lights and wavy lines with or without headache?				
PSYCHIATRIC: (depressed/moody, anxiety, suicidal thoughts, plan or attempts)				
IMMUNIZATIONS: Up to date with: Measles/Mumps/Rubella Tetanus/Pertussis/Diphtheria Hepatitis B Series Flu HPV infection/vaccine discussed				If not up to date, referred to Immunization Program <input type="checkbox"/> Yes <input type="checkbox"/> No
OTHER PROBLEMS:				

ALL THOSE UNDER THE AGE OF 18 ARE ENCOURAGED TO TALK WITH PARENTS AND/OR SIGNIFICANT OTHER

_____ **Client Signature** _____ **Date** _____ **Reviewed By** _____ **Date**

ALL INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT WRITTEN CONSENT, UNLESS REQUIRED BY LAW.