Kodiak Area Native Association
KANA Main Clinic | Mill Bay Health Center
Annual Health History

As a new patient and to help us understand any health issues you may have, please fill out the information below to the best of your ability. All information is confidential.

Patient Name: _____ Date of Birth: _____ Intake Date: _____

Chief Complaint: _____

Allergies: Last physical:

DENTAL SECTION Last dental exam: _____

Have you had problems with prior dental treatment? ☐Yes ☐No

Are you in pain now? ☐Yes ☐No

Have you ever taken Bisphosphonates: ☐Fosamax ☐Actonel ☐Boniva ☐Skelid ☐Didronel ☐Reclast/Zometa

Patient Medical History ***Please check all that apply. Leave blank if unsure.***

☐Measles	☐Hemorrhoids	☐Herpes	☐High/Low Blood Pressure	☐Anemia
☐Mumps	☐IBS/Diverticulitis	☐Tuberculosis	☐Infectious Mono	☐Arthritis
☐Chicken Pox	☐Crohn's Disease	☐Bladder Infections	☐Hepatitis ☐A ☐B ☐C	☐Heart Disease
☐Diphtheria	☐Ulcer	☐Kidney Disease	☐Blood/Plasma Transfusion	☐Aids/HIV
☐Smallpox	☐Glaucoma	☐Hernia	☐Bruising	☐Fibromyalgia
☐Polio	☐Epilepsy	☐Back Trouble	☐Pneumonia	☐Bronchitis
☐Rheumatic Fever	☐Diabetes	☐STD	☐ Mitral Valve Prolapse	☐Stroke
☐Whooping Cough	☐Cancer	☐Head Injury	☐Chronic Fatigue	

☐Other _____

Previous Hospitalizations/Surgeries/Serious Illness/Traumatic Events and Dates:

_____

_____

_____

Medications: ***(Include inhalers, herbs, supplements and over-the-counter items)***

_____

_____

_____

Patient Social History

Marital Status	**Alcohol Use**	**Smoking**	**Smokeless Tobacco**
☐Single ☐Separated	☐Never	☐Never	☐Never
☐Married ☐Widowed	☐Rarely	☐Previously, but quit on:	☐Previously, but quit on:
☐Divorced	☐Moderate	☐Currently Smoking	☐Currently, Amount/Day:
	☐Amount/Day:	Pack/Day:	

Caffeine Use	**Drug Use: Types:**	**Exercise: Type:**
☐Never	☐Never	☐Rare
☐Rarely	☐Rarely	☐Occasional
☐Moderate	☐Occasional	☐Regularly
☐Daily/Amount:	☐Daily/Amount:	☐Daily

Family Medical History: ***Please check if a family member has had any of the following and check the relationship to you***

Diabetes	☐Grandparent	☐Father	☐Mother	☐Sibling	☐Child
Cancer	☐Grandparent	☐Father	☐Mother	☐Sibling	☐Child
Heart Disease	☐Grandparent	☐Father	☐Mother	☐Sibling	☐Child
Hypertension	☐Grandparent	☐Father	☐Mother	☐Sibling	☐Child
Death (*before age 50*)	☐Grandparent	☐Father	☐Mother	☐Sibling	☐Child

***Please give this health history form to your provider.**

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General Health (past year)
☐Good
☐Poor
☐Recent Weight Change:
☐Fatigue/poor energy
☐Sleeping problems/snoring

Ear/Nose/Mouth/Throat
☐Hearing loss
☐Ear pain
☐Ear infections
☐Sinus infections/problems
☐Nose bleeds
☐Mouth sores
☐Bleeding gums
☐Bad breath/bad taste
☐Sore throat
☐Swollen glands in neck
☐Voice change

Cardiovascular
☐Last cholesterol screen:
☐Heart trouble/attack
☐Chest pain/angina
☐Heart medications
☐Heart murmur
☐High blood pressure
☐Shortness of breath at rest
☐Pain in legs
☐Swelling in ankles
☐Varicose veins
☐Cold extremities

Musculoskeletal/Pain
☐Muscles aches/cramping
☐Joint pain
☐Joint swelling
☐Low back pain
☐Neck pain
☐Joint stiffness
☐Difficulty walking/standing
☐Osteoporosis
☐History of injuries and accidents:

Urinary Tract
☐Frequent urination
☐Nighttime urination
☐Urgency/burning/painful
☐Blood in urine
☐Change in urine stream
☐Incontinence or dribbling
☐Kidney stones
☐Sexual difficulty
☐Male: Testicle pain
☐Male: Last Prostate Check:

Skin/Breast/Immune System
☐Rash/itching/hives
☐Dry skin
☐Eczema
☐Psoriasis
☐New or changing moles
☐Breast pain
☐Breast discharge
☐Breast lump
☐Allergies:
☐Food ☐Seasonal
☐Environmental
☐Immune deficiency/compromise

Gastrointestinal
☐Colon cancer screen date:
☐Appetite:
☐ Good ☐ Poor ☐Excessive
☐Recent change in appetite
☐Nausea or vomiting
☐Heartburn/reflux
☐Abdominal pain
☐Bloating
☐Bowel movements: #/day:
☐Easy ☐Difficult
☐Skip days of moving bowels
☐Change in bowel habits
☐Rectal bleeding or blood in stool

Eyes
☐Eye disease or injury
☐Wear glasses/contacts
☐Blurred vision
☐Double vision

Neurological/Psychological
☐Headaches
☐Daily ☐Weekly
☐Migraines
☐Sinus headaches
☐Dizziness
☐Light headed
☐Convulsions or seizures
☐Tremors
☐Paralysis
☐Numbness or tingling
☐Depression
☐Anxiety/nervousness
☐Memory loss/confusion
☐Abuse survivor
☐Trouble sleeping

Female
☐Last menstrual period:
☐Periods are:
☐Regular ☐Irregular
☐Monthly cycle: # of days:
☐PMS:
☐Irritability
☐Emotional
☐Breast tenderness/swelling
☐Other:
☐Vaginal discharge or itching
☐# of pregnancies:
☐# Live births:
Menopause Symptoms:
☐Hot flashes
☐Night sweats
☐Vaginal dryness
☐Other
☐Date of last mammogram:
☐Normal ☐Abnormal
☐Date of last PAP smear:
☐Normal ☐Abnormal

Respiratory
☐Cough
☐Shortness of breath
☐Wheezing/asthma
☐Coughing up blood

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