KODIAK AREA NATIVE ASSOCIATION
HEALTH SERVICES

Annual Health History Form

Please complete the information below to the best of your ability. All information is confidential.

Patient's Full Name: ______________________ Date of Birth: __________

Allergies: __________ Date of Last Physical: __________

Today's Date: ______________________

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 (osteoporosis medication) ☐Yes ☐No *if yes, please list:*

General Health (Past Year)

☐Good ☐Fatigue/Poor Energy ☐Other: __________

☐Poor ☐Sleeping Problems/Snoring

☐Recent Weight Change ☐STDs

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

____

____

____

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

____

____

____

Patient Social History

Alcohol Use	**Caffeine Use**	**Exercise Type**
☐Never ☐Moderate	☐Never ☐Moderate	☐Rare ☐Regularly
☐Rarely ☐Amount/Day: _________	☐Rarely Daily:_________	☐Occasional ☐Daily

Smoking	**Smokeless Tobacco**	**Drug Use; Type:**
☐Never	☐Never	☐Never ☐Occasional
☐Currently, Packs/Day: _________	☐Currently; Amount day: _________	☐Rarely ☐Daily/Amount: _______
☐Previously, but quit on: _________	☐Previously, but quit on: _________	

Family Medical History

Diabetes	Grandparent ☐Type I ☐Type II	Father ☐Type I ☐Type II	Mother ☐Type I ☐Type II	Sibling ☐Type I ☐Type II	Child ☐Type I ☐Type II
Cancer	Grandparent Type: _________	Father Type:_________	Mother Type:_________	Sibling Type: _________	Child Type: _________
Heart Disease	☐Grandparent	☐Father	☐Mother	☐Sibling	☐Child
Hypertension	☐Grandparent	☐Father	☐Mother	☐Sibling	☐Child
Death before 50	☐Grandparent	☐Father	☐Child	☐Sibling	☐Child

Annual Health History Form Cont.

Detailed Patient Health History *Please complete the following to the best of your ability*

Cardiovascular
☐Last cholesterol screen: ________
☐Heart attack; Date: ________
☐Chest pain/angina
☐Heart murmur
☐High Blood pressure
☐Shortness of breath at rest
☐Pain in legs
☐Swelling in ankles
☐Varicose veins
☐Cold extremities
☐Mitral valve prolapse
☐Anemia
☐Rheumatic Fever
☐Blood transfusion

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

Respiratory
☐Cough
☐Shortness of breath
☐Wheezing/asthma
☐Coughing up blood
☐Smallpox
☐Bronchitis
☐Tuberculosis
☐Whooping cough
☐Pneumonia
☐Measles

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

Neurological/Psychological
☐Headaches/Migraines
☐Daily ☐Weekly
☐Dizziness
☐Light headed
☐Convulsions or seizures
☐Tremors
☐Paralysis
☐Numbness or tingling
☐Depression
☐Anxiety/nervousness
☐Memory loss/confusion
☐Abuse survivor
☐Stroke
☐Head injury
☐Polio

Chronic Conditions
☐Diabetes
☐Type I ☐Type II
☐Cancer; Type:________
☐AIDS/HIV
☐Pain
☐Other

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:________
☐Hepatitis
☐A ☐B ☐C

Musculoskeletal/Pain
☐Muscles aches/cramping
☐Joint swelling
☐Back/Neck Pain
☐Difficult walking/standing
☐Osteoporosis
☐Arthritis
☐Fibromyalgia

Digestive System
☐Colon cancer screen date: ________
☐Appetite
☐Good ☐Poor ☐Excessive
☐Nausea or vomiting
☐Heartburn/reflux
☐Ulcers
☐Abdominal pain
☐Bloating
☐Bowel movements
☐Easy ☐Difficult
☐Change in bowel habits
☐Hemorrhoids
☐Infectious mono
☐IBS
☐Diverticulitis
☐Chrohn's Disease

Female
☐Last menstrual period: ________
☐Periods are:
☐Regular ☐Irregular
☐Monthly cycle; # days: ________
PMS:
☐Irritability
☐Emotional
☐Breast tenderness/swelling
☐Other:
☐Vaginal discharge or itching
☐# of pregnancies: ________
☐# of live births: ________
Menopause Symptoms:
☐Hot Flashes
☐Night sweats
☐Vaginal dryness
☐Other:__________
☐Date of last mammogram: ________
☐Normal ☐Abnormal
☐Date of last PAP smear: ________
☐Normal ☐Abnormal
☐Are you currently pregnant?
☐Yes ☐No