Catahoula Parish Hospital District #2

Medical History (Adult 19 years old+)

NAME _____ MALE _____ FEMALE _____ AGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____

DATE OF BIRTH _____ OCCUPATION _____

FAMILY HISTORY

ALLERGY _____ GOUT _____ TUBERCULOSIS _____

ARTHRITIS _____ GLAUCOMA _____ HIGH BLOOD PRESSURE _____

CANCER _____ HEADACHE _____ KIDNEY DISEASE _____

DIABETES _____ HEART ATTACK _____ MENTAL ILLNESS _____

SEIZURES _____ OTHER _____ OTHER _____

ADMISSIONS TO HOSPITAL

YEAR	ILLNESS OR OPERATION	DOCTOR

YEAR	ILLNESS OR OPERATION	DOCTOR

IMMUNIZATIONS

ARE YOUR CHILDHOOD SHOTS UP TO DATE

YES _____

NO _____

LAST TETANUS SHOT _____

LAST HEP B VACCINE _____

CURRENT MEDICATIONS	MEDICINE ALLERGIES

MEDICAL HISTORY (CHECK ALL THAT APPLY)

- ☐ EYE PAIN
- ☐ VISUAL DISTERBANCES
- ☐ HEADACHES
- ☐ DIZZINESS
- ☐ SINUS PROBLEMS
- ☐ MOUTH/THROAT CONDITIONS
- ☐ EAR PROBLEMS
- ☐ HEARING PROBLEMS
- ☐ THYROID DISEASE
- ☐ HEART PROBLEMS
- ☐ CHEST PAIN
- ☐ HIGH BLOOD PRESSURE
- ☐ LUNG PROBLEMS
- ☐ ASTHMA
- ☐ SHORTNESS OF BREATH
- ☐ BREAST DISEASE
- ☐ STOMACH PROBLEMS
- ☐ STOOL/BOWEL PROBLEMS
- ☐ BLOOD IN STOOL
- ☐ VOMITING
- ☐ LIVER DISEASE/HEPATITIS
- ☐ DIABETES
- ☐ LEG PAIN/SWELLING
- ☐ JOINT PAIN/SWELLING
- ☐ STROKE
- ☐ MENTAL ILLNESS
- ☐ DEPRESSION/ANXIETY
- ☐ SKIN PROBLEMS
- ☐ SURGERY
- ☐ BLOOD CLOTS/VERICOSE VEINS
- ☐ BLOOD TRANSFUSIONS
- ☐ SEIZURES
- ☐ FAINTING
- ☐ MEMORY LOSS
- ☐ BLOOD DISORDER
- ☐ ANEMIA
- ☐ SICKLE CELL DISEASE
- ☐ BRAIN/NERVE DISORDER
- ☐ CANCER
- ☐ TERBUCULOSIS
- ☐ SEXUALLY TRANSMITTED DISEASE
- ☐ GENITAL/SEX PROBLEMS

CHILDHOOD DISEASES

- ☐ CHICKEN POX
- ☐ MUMPS
- ☐ MEASLES
- ☐ POLIO
- ☐ RHEMATIC FEVER

SOCIAL

TOBACCO: CHEW __ SMOKE __

ALCOHOL: DAY __ WEEK __ MO __

CAFFEINE: SODA __ COFFEE __

ILLEGAL DRUG USE __

ABUSE MENTAL __ PHYSICAL __

FEMALE

- ☐ PERIODS

AGE ONSET __

REGULAR __

DURATION __ DAYS

BLEEDING BETWEEN __

PAINFUL __

- ☐ VAGINAL DISCHARGE
- ☐ SEX PROBLEMS

OF PREGNANCIES __

OF LIVE BIRTHS __

OF MISCARRIAGES __

OF ABORTIONS __

BIRTH CONTROL METHOD _____

- ☐ MENOPAUSE
- ☐ ABNORMAL PAP
- ☐ ABNORMAL MAMMO

Catahoula Parish Hospital District #2

Medical History (Pediatric Record 0-12 years old)

Patient's Name _____ ☐ Male ☐ Female Age_____

Parent or Guardian's Name _____

Date of Birth_____ Daytime Phone No. _____

HISTORY OF PRESENT ILLNESS

_____

_____

_____

PAST MEDICAL HISTORY:

☐ No previous hospitalization ☐ No major illness

☐ Other _____

ENVIRONMENTAL HISTORY:

☐ Apartment ☐ Private home

☐ Bedrooms _____

☐ Smokers _____

☐ Pets _____

☐ Smoke Detectors _____

☐ Own room

☐ Share room with _____

_____

☐ Persons living in house:

_____

_____

Water/Sewage

☐ City Utilities

☐ Septic tank

☐ Farm water

BIRTH DATA

Age of Mom_____ Gravida/Para _____

Prenatal Care: ☐ Yes (>8 visits) ☐ No

Complications during pregnancy _____

_____

☐ Full term ☐ Premature _____ wks

Type of delivery:

☐ Normal Delivery

☐ C-Section due to _____

Birth weight_____

Birth hospital_____

Complications after delivery _____

_____

FEEDING DATA

☐ Breast feeding_____ mins.

Every_____ hrs.

☐ Formula: Type _____

Amount per feeding_____

Every_____ hrs.

☐ Regular Diet

☐ Special Diet _____

☐ Feeding problems _____

☐ Good appetite

DEVELOPMENTAL FACTS

Held up head _____

Rolled over _____

Sat aided _____

Sat alone _____

Stood alone _____

Walked _____

Said words _____

Toilet trained _____

Grade level _____

FAMILY HISTORY

Mother _____

Father _____

Brothers/Sisters:

1._____ Age___ Sex___ Health___

2._____ Age___ Sex___ Health___

3._____ Age___ Sex___ Health___

4._____ Age___ Sex___ Health___

5._____ Age___ Sex___ Health___

Family Medical History:

☐ Cancer _____

☐ Heart disease _____

☐ Diabetes_____

☐ Anemia_____

☐ Sickle Cell _____

☐ Mental illness_____

☐ High blood pressure_____

☐ Asthma_____

☐ Seizures_____

☐ Bad nerves_____

☐ Tuberculosis_____

☐ Stroke_____

☐ Others _____

_____

ABBREVIATIONS:

MGM — Maternal Grandmother
MGF — Maternal Grandfather
MA — Maternal Aunt
MU — Maternal Uncle
MGA — Maternal Great Aunt
MGU — Maternal Great Uncle
PGM — Paternal Grandmother
PGF — Paternal Grandfather
PA — Paternal Aunt
PU — Paternal Uncle
PGA — Paternal Great Aunt

RECORD OF ILLNESS

Allergies _____

Chicken pox _____

Pneumonia _____

T&A_____

Tonsillitis _____

Ear tube placement _____

Major operations and/or injuries:

_____

_____

Home Meds:_____

_____

ROS: ☐ Regular bowel movement

☐ Good hearing

☐ Good vision

☐ Rashes_____

☐ Other _____

ACCOUNT OF IMMUNIZATIONS

DTap 1._____
2._____
3._____
4._____
5._____

Tdap/Td 1._____
2._____

IPV 1._____
2._____
3._____
4._____

PCV7 1._____
2._____
3._____
4._____

MMR 1._____
2._____

Rota 1._____
2._____
3._____
4._____

HIB 1._____
2._____
3._____
4._____

Var 1._____
2._____

HBV 1._____
2._____
3._____

HAV 1._____
2._____

MCV4 1._____

Other _____

Reviewed by: _____

Catahoula Parish Hospital District #2

Medical History (Adolescent Record 13-18 years old)

ADOLESCENT DATABASE

Please help us help you by carefully filling in the attached medical form. All information you share with us will be kept strictly between you and your medical practitioners.

PAST MEDICAL HISTORY (check Yes or No)

Have you ever had:

- An operation ☐ Yes ☐ No
- To stay over night in a hospital ☐ Yes ☐ No
- A serious injury ☐ Yes ☐ No
- An allergy to food ☐ Yes ☐ No
- An allergy to medicine (e.g., penicillin) ☐ Yes ☐ No
- All allergy to other substances ☐ Yes ☐ No
- Chickenpox ☐ Yes ☐ No
- Tuberculosis ☐ Yes ☐ No
- Rheumatic fever ☐ Yes ☐ No
- Asthma ☐ Yes ☐ No
- Diabetes mellitus ☐ Yes ☐ No
- Sickle cell anemia ☐ Yes ☐ No
- Epilepsy (seizures) ☐ Yes ☐ No
- Pneumonia ☐ Yes ☐ No

Are you currently taking medicines for any Reason? ☐ Yes ☐ No

If so, what is/are the name(s) of the medicines you take?

_____

_____

_____

_____

_____

When was your last booster shot(s)? _____

_____

_____

_____

_____

_____

FAMILY HISTORY

Where were you born?

City _____ State _____

Do you live with yours (check all relatives you live with):

- ☐ Mother
- ☐ Stepmother
- ☐ Father
- ☐ Stepfather
- ☐ Foster parent(s)
- ☐ Grandmother
- ☐ Grandfather
- ☐ Others _____
- ☐ Brother (#_____)
- ☐ Sister (#_____)
- ☐ Niece (#_____)
- ☐ Nephew (#_____)
- ☐ Aunt(s)
- ☐ Uncle(s)
- ☐ Cousin(s)

How long have you there:

☐ Always ☐ Months _____ ☐ Years _____

Does anyone in your family have:

- Diabetes ☐ Yes ☐ No
- High blood pressure ☐ Yes ☐ No
- Asthma ☐ Yes ☐ No
- Heart attack or stroke ☐ Yes ☐ No
- TB (tuberculosis) ☐ Yes ☐ No
- Cancer ☐ Yes ☐ No
- AIDS/ positive HIV test ☐ Yes ☐ No
- Alcohol Abuse ☐ Yes ☐ No
- Drug use ☐ Yes ☐ No

SCHOOL HISTORY

What grade are you in: _____

Are you failing any subject? ☐ Yes ☐ No

If so, what? _____

Have you ever been left back? ☐ Yes ☐ No

Have you ever been in special ed? ☐ Yes ☐ No

What are your plans for the future? _____

_____

_____

Catahoula Parish Hospital District #2

Medical History Ctd. (Adolescent Record 13-18 years old)

Do you have (or have you ever had) problems with:

Too many headaches	☐ Yes	☐ No
Dizzy or fainting spells	☐ Yes	☐ No
Anemia or low blood count	☐ Yes	☐ No
Your eyes	☐ Yes	☐ No
Your teeth	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No
Your heart	☐ Yes	☐ No
Chest pains	☐ Yes	☐ No
Trouble breathing	☐ Yes	☐ No
Stomach pains	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
High or low blood sugar	☐ Yes	☐ No
Urine infections	☐ Yes	☐ No
Your kidney	☐ Yes	☐ No
Frequent rashes or hives	☐ Yes	☐ No
Acne	☐ Yes	☐ No
Swollen joints	☐ Yes	☐ No

...re you or have you ever been on a special diet?	☐ Yes	☐ No
...o you think you are overweight?	☐ Yes	☐ No
...o you think you are underweight?	☐ Yes	☐ No
...o you ever make yourself vomit?	☐ Yes	☐ No
...o you ever binge (really overeat)?	☐ Yes	☐ No
...o you ever try to go a whole day without eating?	☐ Yes	☐ No

...ave you ever had sex?	☐ Yes	☐ No

If you did have sex, at what age did you have sex for the first time? _____

...o you ever feel attracted to someone of the same sex?	☐ Yes	☐ No

...ave you had sex with?

☐ One partner ☐ More than one partner

☐ Opposite Sex ☐ Same sex

...ave you or your partner ever used any birth control methods (condoms, withdrawal or pulling out, pills, etc.)?	☐ Yes	☐ No

If yes, which one(s)? _____

...ould you like to speak to someone about birth control methods?	☐ Yes	☐ No
...ave you ever had a sexually transmitted disease/ VD (such as gonorrhea, chlamydia, syphilis, herpes or chancroid)?	☐ Yes	☐ No

Have you ever had sores or lumps around your penis or vagina?	☐ Yes	☐ No
Have you ever had a discharge from your penis or vagina?	☐ Yes	☐ No
Would you like information about AIDS and safer sex?	☐ Yes	☐ No
Have you ever thought about being tested for HIV/AIDS?	☐ Yes	☐ No
FEMALE: Have you had your first period?	☐ Yes	☐ No

If no, go to next section.

At what age was your first period? _____

How many days did it last? _____

Do your periods come about once a month?	☐ Yes	☐ No

When was your last period? _____

Do you have pain (cramps) with your period?	☐ Yes	☐ No
Have you ever been pregnant, had a miscarriage or abortion?	☐ Yes	☐ No
Have you ever smoked cigarettes?	☐ Yes	☐ No

Have you ever tried:

Marijuana (joint, reefer, chiba)	☐ Yes	☐ No
Angel dust	☐ Yes	☐ No
Cocaine (coke, snow, blow, crack)	☐ Yes	☐ No
Heroin (white lady, smack)	☐ Yes	☐ No
Mescaline, LSD, MDMA (ecstacy)	☐ Yes	☐ No
Pills (ups, downs, etc.)	☐ Yes	☐ No
Alcohol (beer, wine, hard liquor)	☐ Yes	☐ No
Have you ever felt your substance abuse is a problem?	☐ Yes	☐ No
Do you feel depressed (down) a lot?	☐ Yes	☐ No

What do you do to feel better? _____

Have you ever thought about killing/hurting yourself?	☐ Yes	☐ No
If yes, have you ever tried?	☐ Yes	☐ No
Have you ever had counselling with a social worker or other counselor?	☐ Yes	☐ No
Are you having problems at home?	☐ Yes	☐ No
Has anyone ever hit you very hard or beat you?	☐ Yes	☐ No
Has anyone ever touched your body in a way that made you uncomfortable or was without your consent?	☐ Yes	☐ No
Did anyone ever force you or try to force you to have sex?	☐ Yes	☐ No

...eviewed by: _____