UW Medicine
NORTHWEST HOSPITAL & MEDICAL CENTER
INFECTIOUS DISEASE

Patient Label

Health History Form

DATE: _____

NAME: Last _____ **First** _____ **MI**_____**Gender:** ☐ **M** ☐ **F Birthdate:** _____

REASON FOR VISIT: _____

Allergies:	**Medication or Substance**	**Reaction**
☐ No Allergies		

Current Medications:	**Label – Name**	**Dose**	**Frequency**
OR			
☐ See Attached List			

Social History

☐ Single ☐ Married (their name: _____) ☐ Domestic Partner (their name: _____) # Kids _____

Do you use tobacco products? ☐ Daily ☐ Some Days ☐ Quit ☐ Passive (around cigarette smoke) ☐ Never
Packs per Day _____ Years Smoked _____ Date Quit _____
Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Chew ☐ Snuff

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit Date Quit _____
Drinks per Day _____ Drinks per Week _____ Type: ☐ Beer ☐ Wine ☐ Liquor

Do you use recreational drugs? ☐ Never ☐ Yes – Use per Week _____ ☐ No ☐ Quit Date Quit _____
Have you ever used intravenous (IV) drugs: ☐ Yes ☐ No
Types: ☐ Cocaine ☐ Marijuana ☐ Methamphetamines ☐ Stimulants ☐ Heroin
☐ Depressants (downers) ☐Hallucinogens (LSD, mushrooms) ☐ Opioids

Are you sexually active? ☐ Yes ☐ No Partners: ☐ Male ☐ Female ☐ Both Birth Control: _____

Are you working? ☐ Yes What do you do? _____ ☐ No ☐ Retired ☐ Disabled

Medical History — Please check box for those conditions you have now or have ever had

☐ Diabetes Mellitus	☐ Liver Disease	☐ Pneumonia	☐ Sexually Transmitted Infection
☐ Foot Ulcer	☐ Meningitis	☐ Pseudomembranous Colitis	☐ Thrush
☐ H Pylori Infection	☐ Mononucleosis	☐ Rheumatoid Arthritis	☐ Tinea Pedis
☐ Impetigo	☐ MRSA Infection	☐ Shingles	☐ Urinary Tract Infection
☐ Influenza	☐ Osteomyelitis	☐ Sickle Cell Anemia	☐ Varicella
☐ Joint Infection	☐ Peripheral Vascular Disease		
☐ No Past Medical History	☐ Congestive Heart Failure	☐ Headaches	☐ Musculoskeletal
☐ Allergic Rhinitis	☐ COPD	☐ Heart Murmur	☐ Myocardial Infarction
☐ Anemia	☐ Coronary Atherosclerosis	☐ Hepatitis	☐ Osteoporosis
☐ Anesthesia Problems	☐ Depression	☐ HIV	☐ PPD
☐ Anxiety	☐ Diabetes Type 1	☐ Hypertension	☐ Seizures
☐ Arthritis	☐ Diabetes Type 2	☐ Insomnia	☐ Stroke
☐ Asthma	☐ Gastric Ulcer	☐ Kidney Disease	☐ Substance Abuse
☐ Bleeding/Clotting Disorder	☐ GERD	☐ Lipid/Cholesterol	☐ Thyroid Disease
☐ Blood Transfusion	☐ Glaucoma	☐ Lung Disease	☐ Tuberculosis
☐ Cancer			

☐ Other (Please list): _____

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Surgical History — Please check box for any surgery you have had, indicate the year

☐ No Past Surgical History
☐ Abscess Drainage (_____)
☐ Amputation (_____)
☐ Appendectomy (_____)
☐ Breast Surgery(_____)
☐ CABG (_____)
☐ Cholecystectomy (_____)
☐ Dental Surgery (_____)
☐ Gall Bladder (_____)
☐ Joint Replacement (_____)
☐ Orthopedic (_____)
☐ Sinus Surgery (_____)
☐ Skin Grafting (_____)
☐ Spine Surgery (_____)
☐ Splenectomy (_____)
☐ Tonsillectomy (_____)
☐ Valve Replacement (____)

☐ Other (Please list): _____
_____
_____

Family History–Check all that apply

Relationship	First Name	Status (circle)	No Known Problems	Alcohol/Drug Abuse	Arthritis	Asthma	Autoimmune	Cancer	Clotting Disorder	COPD	Depression	Diabetes	Hearing Loss	Heart Disease	Hyperlipidemia	Hypertension	Immunodeficiency	Kidney Disorder	Lipids	Miscarriages	Recurring Infection	Stroke	Sudden Death	Vision Loss
Mother		alive deceased																						
Father		alive deceased																						
Sister		alive deceased																						
Brother		alive deceased																						
Maternal Aunt		alive deceased																						
Maternal Uncle		alive deceased																						
Paternal Aunt		alive deceased																						
Paternal Uncle		alive deceased																						
Maternal Grandmother		alive deceased																						
Maternal Grandfather		alive deceased																						
Paternal Grandmother		alive deceased																						
Paternal Grandfather		alive deceased																						

****Type of Cancer or Disease:** _____

Screening

In the past two weeks, how often have you been bothered by the following? (Please circle one response per statement.)

Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly every day

Have you fallen in the past year? ☐ Yes ☐ No
Are you afraid of falling? ☐ Yes ☐ No
Do you have issues with balance or feeling unsteady? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No

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Review of Systems (current symptoms) – please check only if these are bothering you at this time

Gastrointestinal
☐ Poor Appetite ☐ Nausea ☐ Vomiting ☐ Heartburn/Indigestion ☐ Rectal Bleeding
☐ Stomach Pain ☐ Constipation ☐ Vomiting Blood ☐ Black Tarry Stools ☐ Other: _____
☐ Diarrhea ☐ Abdominal Swelling ☐ Trouble Swallowing ☐ Other: _____ ☐ Other: _____

Constitutional ☐ Fevers ☐ Fatigue ☐ Weight Gain ☐ Weight Loss

Head / Eyes ☐ Cataracts ☐ Dry Eyes ☐ Poor Vision ☐ Color Blindness

Ears/Nose/Mouth/Throat
☐ Hearing Loss ☐ Chronic Sinus Congestion
☐ Heavy Snoring ☐ Bad Teeth

Respiratory (lungs)
☐ Cough ☐ Asthma
☐ Shortness of Breath ☐ Emphysema (COPD)

Heart ☐ Chest Pain ☐ Palpitations ☐ Irregular Heart Beat ☐ High Blood Pressure

Genitourinary ☐ Sexual Problems ☐ Burning with Urination ☐ Blood in Urine ☐ Leakage of Urine

Muscles/Bones ☐ Chronic Pain ☐ Muscle Wasting ☐ Arthritis ☐ Muscle Weakness ☐ Muscle Cramping ☐ Joint Pain

Skin ☐ Rash ☐ Jaundice ☐ Itching ☐ Psoriasis

Neurological ☐ Headaches ☐ Seizures ☐ Confusion ☐ Tremor (shaking)

Vascular ☐ Blood Clots ☐ Varicose Veins

Psychosocial
☐ Anxiety / Nerves ☐ Abusive Relationship ☐ Sexual Difficulties ☐ Insomnia ☐ Alcohol Use
☐ Depression ☐ Feeling Worthless ☐ Want to Hurt Yourself ☐ Want to Hurt Others ☐ Drug Use

Endocrine ☐ Hot Flashes ☐ Intolerance to Heat ☐ Excessive Thirst ☐ Intolerance of Cold

Blood / Lymph ☐ Swollen Lymph Nodes ☐ Easy Bruising ☐ Easy Bleeding