Woodrome Medical, PA
Health Assessment Form Page 1

Please fill out to the best of your ability

Are you allergic to any medications? ☐ Yes ☐ No **If answer is yes, please describe below:**

Medication Name	Describe the reaction (i.e. hives, rash, etc.)

Please list all medications you are currently taking (please include over-the-counter, supplements & contraceptives):

Medication Name	Strength/Dosage	Frequency	Reason Why?

PAST MEDICAL HISTORY: Please indicate if you have been diagnosed with any illnesses below by checking the box.

Illness	✓	Date of Diagnosis	Illness	✓	Date of Diagnosis
AIDS or HIV			Hepatitis (type _____)		
Anemia			High Blood Pressure		
Alcoholism			High Cholesterol		
Allergies (not medication)			Hernia		
Anorexia / Bulimia			Kidney Disease / Failure		
Appendicitis			Liver Disease		
Arthritis			Lung Disease		
Asthma			Measles		
Cancer (type_____)			Migraines		
Chemical Dependency			Mononucleosis		
Chicken Pox			Mumps		
Cataract			Pneumonia		
Depression			Psychiatric Care		
Diabetes			Rheumatic Fever		
Esophageal Reflux			Rubella		
Emphysema / COPD			Ovarian Cysts		
Epilepsy / Convulsions			Stomach Ulcer		
Frequent Kidney/Bladder Infections			Sexually Transmitted Disease		
Frequent Lung Infection			Stroke / Min Stroke		
Gallbladder Disease / Gallstones			Thyroid Problems (type_____)		
Glaucoma / Eye Disease			Tonsillitis		
Gout			Tuberculosis		
Heart Disease			Whooping Cough		

SURGICAL HISTORY: Please list any other operations, hospitalizations, or procedures you have had with date (MM/YY)

Surgery/Hospitalization	Date	Please Describe	Surgery/Hospitalization	Date	Please Describe

Signature of Patient or Guardian_____ **Date**_____

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FAMILY HISTORY: Please indicate if your blood relatives have had any of the following

Illness	Relation	Illness	Relation
AIDS or HIV		Glaucoma / Eye Disease	
Arthritis		Heart Disease	
Asthma		High Blood Pressure	
Bleeding Disorder		Kidney Disease	
Bowel Disease		Lung Disease	
Epilepsy / Convulsions		Psychiatric Care	
Chemical Dependency		Stroke	
Depression		Thyroid Problems	
Diabetes		Tuberculosis	
Cancer (type _____)		Other ?	

SOCIAL HABITS: Have you used any of the following?

Substance	Check One	Amount Per Day?	For How Long?	When Stopped?
Alcohol	☐ Yes ☐ No			
Tobacco Products	☐ Yes ☐ No			
Caffeine	☐ Yes ☐ No			
Street Drugs (type _____)	☐ Yes ☐ No			

Are you sexually active? ☐ Yes ☐ No **How many partners have you had in the last year?**_____
Do you exercise safe sex precautions? ☐ Yes ☐ No **Would you like info on safe sex precautions?** ☐ Yes ☐ No

PREVENTATIVE: Please indicate the last time you had the following test/vaccine (MM/YY). Please note some are age dependent.

Exam	Date	Result?	Vaccine	Date
Cholesterol Testing			Tetanus/Diptheria/Whooping Cough Booser	
Eye Exam with Dilation			Flu Vaccine	
Colonoscopy			Hepatitis B Vaccine	
Tuberculosis Testing			Pneumonia Vaccine	
Stool Occult Blood Testing			Shingles Vaccine	
Males Only: Prostrate Exam			HPV Vaccine	
Males Only: PSA Level				

FEMALE PATIENTS ONLY - GYNECOLOGICAL HISTORY: Please answer the below questions if they are applicable for you.

Test / Exam	Date	Results	Performed By?
Pap Smear			
Clinical Breast Exam			
Mammogram			
Osteoporosis DEXA Scan			
STD and HPV Testing			

Age of onset of menstrual cycle _____ **Are they regular each month?** ☐ Yes ☐ No
Age of onset of menopause _____ **Hysterectomy?** ☐ Yes ☐ No **Have you taken estrogen therapy?** ☐ Yes ☐ No
Preferred Method of Contraception? _____ **Have you ever had an IUD?** ☐ Yes ☐ No
Tubal Ligation? ☐ Yes ☐ No **Number of Pregnancies** _____ **Number of Live Births** _____ **C-Section** ☐ Yes ☐ No
Have you had any miscarriage or complications with pregnancies or deliveries? ☐ Yes ☐ No
If yes, please explain:_____

Signature of Patient or Guardian_____ **Date**_____