Kaukauna Clinic, S.C.
305 E. 12th Street
Kaukauna, WI 54130

HEALTH HISTORY

Patient name: _______________________ Birth date: ___________ Today's date: ___________

This history form provides us with information to help us meet all your healthcare needs. Please complete both sides of this form answering each question. This is a confidential part of your medical record and will be kept in this office.

CHIEF COMPLAINTS: (Please list in order of importance the present health concerns, symptoms, or problems you are experiencing): ____
____
____

Please list all medicines you are currently taking including nonprescription and herbal drugs:
____
____
____

Please list all serious illnesses, accidents, operations and other hospitalizations you have experienced and the year they occurred: ____
____
____

Please list all allergies (drugs, foods and environment): ___________________________________
____
____

Medical history (Do you currently have or have you ever had any of the following symptoms or diseases):

- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Glaucoma
- ☐ High blood pressure
- ☐ Stroke
- ☐ Tuberculosis
- ☐ AIDS/HIV
- ☐ Blood transfusions
- ☐ Osteoporosis
- ☐ Depression
- ☐ Thyroid disease
- ☐ Tire easily
- ☐ Sensitivity to heat or cold
- ☐ Numbness/tingling
- ☐ Hair or nail changes
- ☐ Night sweats
- ☐ Hot flashes
- ☐ Seizures
- ☐ Weakness or paralysis
- ☐ Headaches
- ☐ Dizziness
- ☐ Memory loss
- ☐ Ringing in ears
- ☐ Trouble hearing
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Frequent nose bleeds
- ☐ Sinus problems
- ☐ Frequent colds
- ☐ Chronic cough

☐ Persistent hoarseness
☐ Sort throat (frequent)
☐ Pneumonia
☐ Wheezing/Asthma
☐ Breathing problems
☐ Bloody sputum
☐ Chest pains
☐ Irregular heartbeat
☐ Swelling of hands, feet ankles
☐ Hay fever/allergies
☐ Hemorrhoids
☐ Hernia
☐ Frequent urination
☐ Leakage of urine
☐ Trouble starting urine
☐ Blood in urine
☐ Back pain
☐ Varicose veins
☐ Joint pain or stiffness
☐ Swollen joints
☐ Skin rashes
☐ Psoriasis/eczema
☐ Sleeping difficulties
☐ Suicide thoughts
☐ Venereal diseases
☐ Lack of sex drive
☐ Tattoos

☐ Vision changes
☐ Do you wear glasses/ contacts
☐ Heartburn
☐ Abdominal cramping
☐ Persistent nausea/ vomiting
☐ Ulcers in stomach
☐ Jaundice
☐ Increase in thirst
☐ Change in appetite
☐ Weight gain
☐ Weight loss
☐ Bloody or tarry stools
☐ Chronic diarrhea
☐ Constipation
☐ Chicken pox

Vaccines:
☐ Tetanus ____________
☐ Flu ________________
☐ Pneumonia _________
☐ Chicken pox _______
☐ Hepatitis B ________
☐ COVID _____________

Males only:
☐ Discharge from penis
☐ Pain or lump in testicles
☐ Impotence
☐ Prostate problems

Females only:
Age period began ______
Days of flow ___________
Days between periods __
☐ Heavy flow
☐ Pain/ cramps
☐ Pain with intercourse
☐ History of abnormal pap test? ___________
Date of last pap smear _______________________
Type of birth control _______________________
# of pregnancies ________
Full term ____________
Preterm_____________
Miscarriages ________
Abortions ___________
Menopause age _______
☐ History of breast problems
Do you do breast self-exams? _______________
Date of last mammogram _______________________

When was your last physical exam? _________ When was your last dental exam? ________
When was your last eye exam? ___________

Habits:

Smoking- cigarettes or cigars
Per day ________ # of years ________ If former smoker, date quit ____________
Chew- amount ______________
Alcohol- type ______________ amount per week ________
Street drugs- type ___________ amount ____________
Caffeine- type ____________ amount per day ________
Exercise- type ________________ frequency ___________
Do you wear a seatbelt? _________
Do you keep firearms in your home? ________ If yes, are they in a locked case? __________

Children:

Are vaccines up to date? ________

(Please provide us with a copy of the immunization record)

Are there any behavioral problems? ________

Family History:

☐ Cancer	☐ Arthritis	☐ Alcoholism
☐ Tuberculosis	☐ Glaucoma	☐ Obesity
☐ Diabetes	☐ Migraines	☐ Hepatitis
☐ Heart disease	☐ Depression	☐ AIDS/HIV
☐ High blood pressure	☐ Epilepsy	☐ Allergies
☐ Stroke	☐ Easy bleeding	
	☐ High cholesterol	

List the present age or the age of death of each of the following family members. If deceased, list the cause of death.

Mother ____

Father ____

Sister (s) ____

Brother (s) ____

Spouse ____

Children ____

Maternal Grandmother ____

Maternal Grandfather ____

Paternal Grandmother ____

Paternal Grandfather ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Signature ___________________________________ Date ____________________

Provider's comments:

Provider's signature ____________________________ Date ___________________