Kaukauna Clinic, SC
"Your partners in Family Health Care"

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

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 _____