

ADOLESCENT/ADULT HEALTH HISTORY

Date

8-20-15

Name

Kia Holloway

1. What is the reason for your visit today? I believe my pressure is still elevated
2. Is there anything about you and your health that we need to know? recently had injury to right shoulder
3. List medicine, drugs, or food you are allergic to: none that I am aware of
4. List any medicines or drugs you take: 800mg Ibreprofen

5. Have YOU or anyone in your family had any of the following: (circle)

heart disease
high blood pressure
stroke

diabetes/sugar
blood problem or disease
cancer

tuberculosis
birth defects
mental retardation

nerve or mental problems
asthma
died before age 50
other "family" disease

6. Have you ever been in the hospital? yes Why? ovary removal
7. Have you ever had surgery? yes Why? listed above
8. Have you ever had a serious accident? no
9. Have you had serious or recent problems with:

ears or throat
allergies
lung infections

NO YES
NO YES
NO YES

cough
thyroid
skin problems

NO YES
NO YES
NO YES

kidneys
weight loss
ulcers

NO YES
NO YES
NO YES

gallbladder
liver
depression
headaches

NO YES
NO YES
NO YES
NO YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? NO YES
11. Have you ever had a blood clot in your lungs, legs or anywhere? NO YES
12. Have you ever smoked cigarettes or used smokeless tobacco? NO YES
- If yes, are you an: Ex-smoker Smoking now? Do you smoke (less) (more) than a pack a day?
- How much smokeless tobacco do you use a day?
13. How often do you drink beer, wine, wine coolers, or liquor?
- Never Rarely 1-2 times a week 3-4 times a week 5 or more times a week
- If you drink beer, wine, wine coolers, or liquor, do you have:
- (less) (more) than 5 drinks a day?

14. Have you ever used marijuana, cocaine, crack or other drugs? NO YES
15. Have you ever used I.V. drugs? NO YES
16. Have you ever had a blood transfusion? NO YES
17. Do you have any tattoos? NO YES
18. Have you ever been treated for a venereal disease? NO YES
19. Have you had more than one sex partner in the past 5 years? NO YES
20. Have you ever had sex with a member of your own sex? NO YES
21. Have you had or been around anyone with hepatitis? NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? NO YES

FOR FEMALES ONLY

approx 4th

- A. How old were you when you started your periods? 12 Date of your last period? this month spotting
- How often do you have your periods? varies Are they regular? not now
- How many days do they last? varies
- Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge
- B. Do you have any problems with your breasts (lumps, discharge, or other)? NO YES
- Do you check them regularly? YES NO
- C. How many times have you ever been pregnant? 4 How many children are living? 4
- Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? NO YES
- Were any of your children premature? NO YES
- How old were you when your first child was born? 1
- D. Have you ever used: (circle NO/YES) birth control pills? NO YES; foam? NO YES; condoms? NO YES; IUD? NO YES; diaphragm? NO YES
- E. Did you have problems with any of these methods? NO YES
- F. Have you ever had an abnormal PAP smear? NO YES

Date 3-4-13Name Kia Hatley

1. What is the reason for your visit today? right ear ache
2. Is there anything about you and your health that we need to know? no

- *3. List medicine, drugs, or food you are allergic to: None
- *4. List any medicines or drugs you take: none

5. Have YOU or anyone in your family had any of the following: (circle)

heart disease
high blood pressure
stroke

diabetes/sugar
blood problem or disease
cancer

tuberculosis
birth defects
mental retardation

nerve or mental problems
asthma
died before age 50
other "family" disease

6. Have you ever been in the hospital? yes Why? right ovary removal
7. Have you ever had surgery? yes Why? " " " cervical cancer cells removed
8. Have you ever had a serious accident? no
9. Have you had serious or recent problems with:

ears or throat
allergies
lung infections

NO YES
NO YES
NO YES

cough
thyroid
skin problems

NO YES
NO YES
NO YES

kidneys
weight loss
ulcers

NO YES
NO YES
NO YES

gallbladder
liver
depression
headaches

NO YES
NO YES
NO YES
NO YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? NO YES
11. Have you ever had a blood clot in your lungs, legs or anywhere? NO YES
- *12. Have you ever smoked cigarettes or used smokeless tobacco? NO YES

If yes, are you an: Ex-smoker? Smoking now? Do you smoke (less) (more) than a pack a day?

How much smokeless tobacco do you use a day? less than a pack

- *13. How often do you drink beer, wine, wine coolers, or liquor?
- Never Rarely 1-2 times a week 3-4 times a week 5 or more times a week

If you drink beer, wine, wine coolers, or liquor, do you have:

(less) (more) than 5 drinks a day?

- *14. Have you ever used marijuana, cocaine, crack or other drugs? NO YES
- *15. Have you ever used I.V. drugs? NO YES
16. Have you ever had a blood transfusion? NO YES
17. Do you have any tattoos? NO YES
18. Have you ever been treated for a venereal disease? NO YES
19. Have you had more than one sex partner in the past 5 years? NO YES
20. Have you ever had sex with a member of your own sex? NO YES
21. Have you had or been around anyone with hepatitis? NO YES
22. Would your sex partner(s) answer Yes to any of the questions 14-22? NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? 14 Date of your last period? Feb. 2012
- How often do you have your periods? monthly Are they regular? yes
- How many days do they last? 5-6
- Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge None
- B. Do you have any problems with your breasts (lumps, discharge, or other)? NO YES
- Do you check them regularly? YES NO
- *C. How many times have you ever been pregnant? 3 How many children are living? 4
- Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? NO YES
- Were any of your children premature? NO YES
- How old were you when your first child was born? 19
- D. Have you ever used: (circle NO/YES) birth control pills? NO YES; foam? NO YES; condoms? NO YES; IUD? NO YES; diaphragm? NO YES
- E. Did you have problems with any of these methods? NO YES
- F. Have you ever had an abnormal PAP smear? NO YES