



SAFETY NET CLINIC
Health History Questionnaire

Date: ____/____/____

Chart#: _____

Name: _____ Date of Birth: ____/____/____

Address: _____

City: _____ State: ____ Zip: _____ SS#: _____ - _____ - _____

Telephone: _____ (Home) _____ (Cell)

Emergency Contact _____ Relationship: _____

Address: _____ Telephone: _____

How did you hear about the Safety Net Clinic? _____

Why are you visiting here today? _____

PERSONAL MEDICAL HISTORY

Check symptoms/conditions you currently have or have ever had in the past

- AIDS
- Alcoholism
- Allergies/Hay Fever
- Anemia (low blood)
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Benign Prostatic Hypertrophy
- Bipolar Disorder
- Bleeding Disorders/Bruising
- Bladder Infections
- Bronchitis
- Bulimia
- Cancer Type _____
- Cataracts
- Chicken Pox
- Depression
- Diabetes
- Drug Addiction
- Emphysema
- Epilepsy (fits, seizures)

- Fibromyalgia
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High Blood Pressure
- High Cholesterol
- HIV Positive
- Kidney Disease/Infections
- Lactose Intolerance
- Leg Pain
- Liver Disease
- Lupus
- Menopause
- Migraine Headaches
- Mononucleosis
- Multiple Sclerosis
- Pacemaker

- Pelvic Inflammatory Disease
- Pneumonia
- Prostatitis
- Sarcoidosis
- Schizophrenia
- Shingles
- Sickle Cell Disease
- Stomach Problems/ Ulcers
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Ulcers
- Urethritis
- Uterine Fibroids
- Varicose Veins
- Other _____

SYMPTOMS/CONDITIONS

Check symptoms you currently have or have had in the past month.

General

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Frequent Headaches
- Frequent Tiredness
- Loss of sleep
- Loss of weight
- Loud snoring
- Nervousness
- Numbness
- Sweats
- Thirst

Gynecological (Women Only)

- Breast lump
- Hot flashes
- Nipple discharge
- Pain during sex
- Unpleasant vaginal odor
- Vaginal discharge
- Vaginal infections
- Vaginal itching or burning

Muscle/Joint/Bone

Pain, weakness, numbness or tingling in:

- Arms
- Hips
- Back
- Legs
- Feet
- Neck
- Hands
- Shoulders

Eye, Ear, Nose, Throat, Lungs

- Bleeding gums
- Blurred vision
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hoarseness
- Loss of hearing
- Nasal congestion
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes
- Vision – Halos
- Wheezing

Urinary

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination
- Penile discharge
- Strong urge to urinate
- Urinating more than 3 times a night

Cardiovascular

- Chest pain
- Shortness of breath
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

Gastrointestinal

- Appetite poor
- Bloating
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

Skin

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sores that won't heal

List the medications that you are currently taking.

Are you allergic to any foods or medicines? Yes No

If yes, what items? What happens to you when exposed to these items? _____

Have you ever been hospitalized? Yes No If yes:

Year _____ Reason _____

Year _____ Reason _____

Year _____ Reason _____

Have you ever had surgery? Yes No If yes:

Year _____ Procedure _____

Year _____ Procedure _____

Year _____ Procedure _____

How many times a week do you exercise? _____ What types of exercise(s) do you do? _____

How would you describe your health on a scale of 1 to 10 (1 being poor and 10 being excellent)?

1 2 3 4 5 6 7 8 9 10
poor excellent

FAMILY HISTORY

Does anyone in your family have the following conditions? Relationship (mother, father, brother, sister, child)?

Allergies () _____

Asthma () _____

Dementia () _____

Diabetes () _____

Heart Disease () _____

High Blood Pressure () _____

Kidney Disease () _____

Tuberculosis () _____

Cancer – What type? () _____

SEXUAL HISTORY

Have you ever had any of the following?

- Gonorrhea
- Chlamydia
- Trichomonas
- Herpes
- Syphilis
- Yeast
- Bacterial Vaginosis
- Human Papiloma Virus (HPV)

Have you ever had sex with?

- Men
- Women
- Both

Have you ever had sex with someone who is an IV drug user, or who is bisexual or gay? Yes No

Are you experiencing any problems with sexual intercourse? Yes No

If yes, what and how often? _____

Do you use condoms to protect yourself from STDs (Sexually Transmitted Diseases)? Yes No

If not, why not? _____

OB/GYN HISTORY (Women Only)

General

Have you ever had a pap smear? Yes No

Date of last pap smear ____/____/____

Have you ever had an abnormal pap smear?

Yes No

If yes, when and where were you treated?

____/____/____

Do you do breast self-exams every month?

Yes No

If no, how often? _____

Do you have any discharge from your breasts?

Yes No

Do you have any breast masses or lumps?

Yes No

Date of last mammogram? ____/____/____

Normal Results

Abnormal Results

Are you sexually active? Yes No

Menstrual History

Age you were when periods started _____

Have you gone through menopause?

Yes No

Are your periods regular?

Yes No Varies

Date of last period ____/____/____

How many days are your there from the start of one period to the beginning of the next? _____

How many days do your periods last? _____

Flow: Light Medium Heavy

Describe the intensity of pain you experience with your periods: None Mild Moderate

Severe Crippling

Do you have bleeding or spotting between your periods?

Yes No

Do you have bleeding or spotting after sex?

Yes No

Birth Control

What method(s) for birth control do you currently use? _____

Have you ever taken birth control pills?

Yes No

If yes, when and for how long? _____

Other form(s) of birth control you have used:

Pregnancy History

Have you ever been pregnant? Yes No

If yes, how many times have you been pregnant? ____

Have you ever had an abortion? Yes No

If yes, how many? _____

When? _____

How many children do you have? _____

Do you breastfeed? Yes No

Have any of your children died?

Yes How many? _____ No

Were any of your children premature?

Yes No

Have you ever had a miscarriage, stillborn child, or abortion? Yes No

How old were you when you had your first child?

Do you have infertility problems? Yes No

If yes, please describe: _____

SOCIAL HISTORY

What is your current work status?

- Unemployed
 Part-Time job
 Full-Time job

What is the highest grade level you have completed?

- Elementary (grades 1 – 8)
 High School (grades 9 – 12)
 GED
 HS diploma
 Vocational training
 Some college
 Bachelor's degree
 Graduate degree

Do you smoke cigarettes or cigars? Yes No

If yes, how many per day? _____

If yes, for how many years? _____

Do you chew tobacco? Yes No

If yes, how often per day? _____

Do you drink beer, wine or liquor? Yes No

If yes, do you do so: Daily Weekly

Monthly Every now and then

For how many years? _____

Do you use any of the following drugs?

To answer please use the codes below:

Past/Current (P/C)

Daily/Weekly/Monthly/Every Now & Then (D/W/M/E)

For how many years?

Crystal Meth: Yes No

If yes: _____
P/C D/W/M/E # of years

Marijuana/Blunts: Yes No

If yes: _____
P/C D/W/M/E # of years

Heroin: Yes No

If yes: _____
P/C D/W/M/E # of years

Crack: Yes No

If yes: _____
P/C D/W/M/E # of years

Cocaine: Yes No

If yes: _____
P/C D/W/M/E # of years

Have you ever been kicked, hit, or punched by your spouse/boyfriend/girlfriend/partner?

Yes No

If yes, when ____/____/____

If yes, are you still dating or living with this person?

Have you ever been forced to have sex? Yes No

If yes, at what age? _____

NUTRITION HISTORY

How many fruits and vegetables do you usually eat each day?

0 – 2 _____ 3 – 5 _____ 6 or more _____

How many servings of caffeine (e.g. coffee, tea, Coke) do you have a day?

None _____ 1 – 3 _____ 4 – 6 _____ more than 6 _____

YOUR HEALTH INTERESTS

Are you interested in attending workshops, seminars, or classes on any of the following health topics? Check all that apply.

- Aerobics/Exercise
 Depression
 Diabetes

- Heart Disease/Hypertension
 Nutrition/Diet
 Smoking Cessation

**Directions to
The Center for Black Women's Wellness, Inc**

Traveling **North on I-75/85** take **exit 246**, which will be the Fulton Street exit. When you exit the expressway make a left on to Fulton Street, come to the fifth light, this will be the intersection of Fulton and Windsor Streets, make a left on to Windsor Street and turn right into the first driveway, this will be the Dunbar community Center. We are located on the 3rd floor, Suite 309.

Traveling **South on I-75/85** take **exit 246**, which will be the Fulton Street exit. When you exit the expressway make a right on to Fulton Street, come to the fourth light, this will be the intersection of Fulton and Windsor Streets, make a left on to Windsor Street and turn right into the first driveway, this will be the Dunbar community Center. We are located on the 3rd floor, Suite 309.

Traveling **East on I-20** take **exit 56B** which will be the Windsor/Spring Street exit. When you exit the expressway make a right onto Windsor Street, go through one traffic light and turn into the first driveway on the right, this will be the Dunbar community Center. We are located on the 3rd floor, Suite 309.

Traveling **West on I-20** take **exit 56B** which will be the Windsor/Spring Street exit. When you exit the expressway make a left onto Windsor Street, go through two traffic lights and turn into the first driveway on the right, this will be the Dunbar community Center. We are located on the 3rd floor, Suite 309.

From **Downtown** travel south on Spring Street, going toward I-20 and Turner Field. Once you cross Fulton Street, turn into the first driveway on the right, this will be the Dunbar community Center. We are located on the 3rd floor, Suite 309.

travel south Pryor Street and make a right on to Fulton Street come to the 3rd traffic light and make a left onto Windsor Street, we located inside of the Dunbar Community Center, which will be the first driveway on your right.