HEALTH HISTORY DATA TRANSMITTAL WORKSHEET

Patient Label

TENNESSEE DEPARTMENT OF HEALTH
Community Health Services

MEDICAL HISTORY OF PATIENT (PLEASE CHECK ALL THAT APPLY)

❑ Anemia	❑ Chicken Pox	❑ Kidney/Bladder Disease	❑ Sickle Cell
❑ Anxiety	❑ Depression	❑ Liver Disease/Hepatitis	❑ Disease
❑ Arthritis	❑ Diabetes	❑ Lung Disease/Tuberculosis	❑ Trait
❑ Asthma	❑ Eating Disorder	❑ Measles	❑ Skin Disorder
❑ Birth Defect/Genetic Disorders	❑ Epilepsy/Seizures	❑ Mental Health Problems	❑ Stroke
❑ Blood disorder	❑ Fainting	❑ Mononucleosis	❑ Suicidal Thoughts
❑ Blood clot	❑ Gallbladder Disease	❑ Mumps	❑ Thyroid Disease/Goiter
❑ Bowel/Stomach Problems	❑ Hearing Impaired	❑ Obesity	❑ Ulcers
❑ Breast Disease	❑ Heart Disease/Attack	❑ Physical Activity Limitations	❑ Varicose Veins
❑ Cancer	❑ High Blood Pressure	❑ Severe Headaches	❑ Vision Problems:
Type:_____	❑ High Cholesterol	❑ Sexual Problems	❑ Wears Glasses or Contacts
	❑ HIV/AIDS	❑ Sexual Transmitted Disease	❑ Other: _____

Have you ever had a mammogram? □ YES □ NO
If yes, have you ever had one that was abnormal?
□ YES □ NO

Have you ever had a colonoscopy? □ YES □ NO
If yes, have you ever had one that was abnormal?
□ YES □ NO

SURGERIES	DATE	HOSPITALIZATIONS/INJURIES	DATE

FAMILY MEDICAL HISTORY OF PATIENT (Please check appropriate box of family member for all that apply)

ARE YOU ADOPTED? □ YES □ NO □ UNKNOWN

	Father	Mother	Father's Parents	Mother's Parents	Brother Sister		Father	Mother	Father's Parents	Mother's Parents	Brother Sister
Anemia						High Cholesterol					
Birth Defects/ Genetic Disorders						High Blood Pressure					
Blood Disorder						Kidney Disease					
Cancer (specify type)						Lung Disease					
Diabetes						Mental Illness					
Epilepsy/Seizures						Obesity					
Glaucoma						Sickle Cell (specify Disease or Trait)					
Heart Disease/Attack											
Other:						Stroke					

IF THE CHILD BEING SEEN TODAY IS UNDER 6 YEARS OF AGE COMPLETE THIS SECTION				
Birth Weight	Birth Length	❑ Vaginal Birth	❑ C-Section	❑ Premature Birth (less than 36 weeks)
❑ Pregnancy Complications:			❑ Delivery Complications:	
When did you begin prenatal care? ❑ 1st Trimester (0-13 Weeks) ❑ 2nd Trimester (14-26 Weeks) ❑ 3rd Trimester (27-40+ Weeks) ❑ None ❑ Unknown		Did your baby have a Newborn Screening Test (Heel Stick)? ❑ Yes ❑ No Hospital of Birth:		Did your baby have a Newborn Hearing Test? ❑ Yes ❑ No Length of Hospital Stay:

Advance directives for health care (age 18 and above only)
Have you finalized any advance health directives? (examples–living will, durable power of attorney, organ donation, "do not resuscitate" instructions) □ YES □ NO If not, would you like information? □ YES □ NO Information Given □ YES □ NO

Male only	MEDICAL HISTORY CONTINUED (If appropriate for the patient being seen today please complete the section below)		
Reproductive Health Questions	**Answer**	**Reproductive Health Questions**	**Answer**
Have you ever experienced sexual or physical abuse?		Does your sex partner have sex with men?	
Have you ever had sex?		Has your sex partner ever been in prison?	
How old were you the first time you had sex?		Has your partner(s) ever had an STD?	
How many sex partners have you had?		Has your partner(s) ever had HIV?	
How many sex partners have you had in the past 6 months?		Have you ever had an STD?	
Have you had sex with men, women, or both?		Have you ever had an AIDS test?	
Does your sex partner use IV street drugs?		Have you ever been diagnosed with HIV/AIDS?	
Does your sex partner have sex with other women?			

Female only	MEDICAL HISTORY CONTINUED (If appropriate for the patient being seen today please complete the section below)
Have you ever experienced sexual or physical abuse?	Has your partner(s) ever had HIV?
Did your mother take DES (hormones) while pregnant with you?	Have you ever had an STD?
Age at time of first period	Have you ever had an AIDS test?
Do you have a period every month?	Have you ever been diagnosed with HIV/AIDS?
Average number of days menstrual bleeding	How many times have you been pregnant?
Is your bleeding heavy, medium, or light?	How many pregnancies resulted in a live birth?
Do you have cramps with your period?	How many pregnancies ended in miscarriage?
What medicine do you take for cramps?	How many pregnancies ended in stillbirth?
When, if ever, would you like to be pregnant? ❑ No ❑ Unsure or okay either way ❑ Yes, I want to be pregnant in the next year ❑ Yes, I want to be pregnant in 2 or more years	How many pregnancies ended in abortion? How many cesarean births have you had? Did you have any problems during a pregnancy? When was your last delivery? Did you have a check-up after your last delivery?
Have you ever had sex?	Are you breastfeeding?
How old were you the first time you had sex?	What was the birth weight of your smallest baby?
How many sex partners have you had?	What was the birth weight of your largest baby?
How many sex partners have you had in the past 6 months?	When was your last Pap smear done?
Have you had sex with men, women, or both?	Was your last Pap smear normal?
Does your sex partner use IV street drugs?	Have you ever had an abnormal Pap smear?
Does your sex partner have sex with other women?	If you've had an abnormal Pap, when was that?
Does your sex partner have sex with men?	If you've had an abnormal Pap, were you treated?
Has your sex partner ever been in prison?	What other methods of birth control have you tried?
Has your partner(s) ever had an STD?	Have you had problems with any methods?