

**WOODSON CENTER FOR ADULT HEALTHCARE**  
**CHERYL E. WOODSON, M.D.**

**WE WANT TO GET TO KNOW YOU. FILL OUT THIS PERSONAL HEALTH HISTORY AND IMMUNIZATION RECORD  
 AND BRING IT TO YOUR VISIT. IF YOU NEED HELP, WE WILL BE HAPPY TO ASSIST YOU**

Name \_\_\_\_\_

Date \_\_\_\_\_

Birth Date \_\_\_\_\_

Male     Female

Spiritual Affiliation \_\_\_\_\_

Pharmacy \_\_\_\_\_

**YOUR HEALTH HISTORY**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Abdominal Pain               | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Heart Surgery/Valve Bypass | <input type="checkbox"/> Palpitations / Heart Flutters |
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Diarrhea                   | <input type="checkbox"/> Hemorrhoids                | <input type="checkbox"/> Pain                          |
| <input type="checkbox"/> Appendicitis                 | <input type="checkbox"/> Difficulty Breathing       | <input type="checkbox"/> Hernia                     | <input type="checkbox"/> Pneumonia                     |
| <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Difficulty Swallowing      | <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Ringing In Ears               |
| <input type="checkbox"/> Asthma/COPD/Emphysema        | <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Hoarseness                 | <input type="checkbox"/> Seizure                       |
| <input type="checkbox"/> Back Pain                    | <input type="checkbox"/> Double Vision              | <input type="checkbox"/> Kidney Stones              | <input type="checkbox"/> Sexual Problems               |
| <input type="checkbox"/> Bladder / Kidney Infection   | <input type="checkbox"/> Problems With Erection     | <input type="checkbox"/> Leg Cramps                 | <input type="checkbox"/> Sexually Transmitted Disease  |
| <input type="checkbox"/> Blood In Urine               | <input type="checkbox"/> Falls / Difficulty Walking | <input type="checkbox"/> Leg Ulcer                  | <input type="checkbox"/> Sinus Problems                |
| <input type="checkbox"/> Blood In Stool               | <input type="checkbox"/> Gallbladder Disease        | <input type="checkbox"/> Liver Disease / Jaundice   | <input type="checkbox"/> Skin Rash                     |
| <input type="checkbox"/> History Of Blood Transfusion | <input type="checkbox"/> GERD / Heartburn           | <input type="checkbox"/> Loss Of Consciousness      | <input type="checkbox"/> Stomach Ulcer                 |
| <input type="checkbox"/> Blurred Vision               | <input type="checkbox"/> Gout                       | <input type="checkbox"/> Memory Loss                | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Bone Fracture                | <input type="checkbox"/> Headache                   | <input type="checkbox"/> Mental Illness             | <input type="checkbox"/> Thyroid Disease (Over/Under)  |
| <input type="checkbox"/> Bowel Trouble/Constipation   | <input type="checkbox"/> Heart Attack               | <input type="checkbox"/> Muscle Weakness            | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Heartburn                  | <input type="checkbox"/> Night Sweats               | <input type="checkbox"/> Tonsillectomy                 |
| <input type="checkbox"/> Chest Pain                   | <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Nose Bleeds                | <input type="checkbox"/> Leaking Urine                 |
| <input type="checkbox"/> Cough                        | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Obesity / Overweight       | <input type="checkbox"/> Weight Loss                   |

**FAMILY HISTORY**

	Age If Living	Age At Death Cause?	Heart Attack What Age?	High Blood Pressure	Stroke	Diabetes	Kidney Disease	Cancer What Type?	Mental Illness and/or Memory Loss	Arthritis	Other
Father											
Mother											
Brothers											
Sisters											
Paternal Grandfather											
Paternal Grandmother											
Maternal Grandfather											

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Maternal Grandmother											
Other											

**Female Menstrual History**

Age At Onset: \_\_\_\_\_  Regular  Irregular

Days Of Flow: \_\_\_\_\_  Heavy  Medium  Light

Length Of Cycle: \_\_\_\_\_ Last Menstrual Period \_\_\_\_\_

Number Of Pregnancies: \_\_\_\_\_ Live Births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_

Living Children: \_\_\_\_\_ Stillbirths: \_\_\_\_\_ C-Sections: \_\_\_\_\_

Hot Flashes  Menopause  Painful Intercourse  Post-Menopausal Bleeding

Sexual Satisfaction:  Yes  No

**HOSPITALIZATIONS**

**OPERATIONS**

Date	Hospital

Date	Type of Operation

**Medications (Prescribed, Over-the-counter, Vitamins, etc.)**  
**PLEASE INCLUDE EVERYTHING- TAKE ALL THE SPACE YOU NEED**

Name of Medication	Date Started	Dosage	Times/Day	Action	Side Effects

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**Allergies**

Allergy	Date First Noticed	Describe Reaction

**Primary Care**

IMMUNIZATIONS	DATES
Tetanus	
Flu	
Pneumonia	
Shingles Vaccine	
Gardasil (HPV)	
Hepatitis A	
Hepatitis B	
Meningococcal	
TB Test	
Exposure To TB?	Yes _____ No _____

EXAM / TEST	DATES
Mammogram	
PAP	
Rectal Exam / Colonoscopy	
Bone Density / DEXA	
Prostate (Exam, Blood)	
Cholesterol	
Other Blood Work	
Dental	
Hearing	
Eye Exam	

**If you are DIABETIC**

**HgbA1c (% protein covered with sugar)**

**Urinary microalbumin (measure of protein in urine)**

**Podiatry (foot doctor)**

**Social History**

Are you satisfied with how well you read? \_\_\_\_\_

Highest Level of Education Achieved? \_\_\_\_\_

Occupation: \_\_\_\_\_

Military Service? \_\_\_\_\_

Marital Status (*Circle One*):      Married              Single              Widowed              Divorced

Sexual Orientation (*Circle One*):      Heterosexual              Homosexual              Bisexual

Sexually Active:       Yes               No

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(Circle) Monogamous or Multiple Partners # Of Partners: \_\_\_\_\_

Do you have any behaviors that put you at risk for HIV? \_\_\_\_\_

Any Sexual Problems: \_\_\_\_\_

What Type of Birth Control? \_\_\_\_\_

Alcohol Consumption:  Yes  No # Of Drinks Per Week: \_\_\_\_\_

Tobacco Use:  Yes  No # Of Packs Per Day: \_\_\_\_\_ # Of Years: \_\_\_\_\_

Any Recreational Drugs? \_\_\_\_\_

Do You Exercise:  Yes  No How Often Do You Exercise? \_\_\_\_\_

What Type of Exercise? \_\_\_\_\_

**Advance Directives**

If you were too sick to speak for yourself, who would make health care decisions for you?

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Relationship**

Have you prepared a Living Will, or Health Care Power Of Attorney?  Yes  No

If you were too sick to eat or breathe on your own, would you want to be kept alive on machines?  Yes  No

Have you discussed your wishes with your family?

**HAVE WE MISSED ANY TOPICS THAT ARE IMPORTANT TO YOU??**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Thanks for taking the time to give us this information. WELCOME TO WOODSON CENTER!**