*Do not fax, keep in records*

# NEWCOMER HEALTH PROGRAM
# INDIVIDUAL HEALTH HISTORY

DATE: _____

**CHECK BELOW IF YOU OR ANY FAMILY MEMBER HAVE THESE:**

| | YOU | FAMILY | | YOU | FAMILY | OFFICE USE ONLY |
|---|---|---|---|---|---|---|
| 1. Allergies (food/drug/latex/insects/seasonal) | | | 19. Genetic Diseases | | | |
| 2. Anemia (low blood iron)/sickle cell or trait | | | 20. Heart Problems/Murmurs | | | |
| 3. Asthma or bronchitis | | | 21. Hepatitis or liver disease | | | |
| 4. Arthritis | | | 22. High blood pressure | | | |
| 5. Birth Defects | | | 23. HIV/Sexually Transmitted Infection | | | |
| 6. Bladder/Kidney Problems | | | 24. Intellectual disability/Learning problems | | | |
| 7. Blood clots (legs or lungs) | | | 25. Mental illness/Depression/ Depression after birth | | | |
| 8. Blood disease or bleeding | | | 26. Migraine headache | | | |
| 9. Bone problems | | | 27 Muscle/Joint problems | | | |
| 10. Cancer | | | 28. Skin problems | | | |
| 11. Deafness/Ear problems/Tubes | | | 29. Stroke | | | |
| 12. Dental Problems | | | 30. Suicide/thoughts/attempt | | | |
| 13. Diabetes (sugar) | | | 31. Thyroid problems | | | |
| 14. Diarrhea/Constipation/Bowel Problem | | | 32. Throat problems | | | |
| 15. Eating of non-food items | | | 33. Tuberculosis/other lung problem | | | |
| 16. Epilepsy/Seizures | | | 34. Vision/Eye problem | | | |
| 17. Feeding Problems/Special Diet | | | 35. Other | | | |
| 18. Gall Bladder Problems | | | 36. Other_____ | | | |

G____P____A____ LMP: _____

Have you ever been hospitalized? YES ____ NO _____ If YES; List dates and why_____

Do you drink alcohol/beer/wine/liquor? YES ____ NO _____ If YES, how much?_____

Do you use cigarettes/tobacco products? YES ____ NO _____ If YES, how much?_____

Do you have any tattoos/body art/body piercings/traditional or tribal scars or markings? YES ____ NO _____ Describe:_____

_____

If you are on any medications, please list: _____

Do you use any traditional herbs or remedies? YES ____ NO _____ If YES, what and how often?_____

Country of Birth and Primary Language_____ Current Occupation/School _____

Do you live in house___ apartment____ mobile home____ motel____ shelter ___ other _____? Number of persons living in household: _____

_____

For Office Use Only:
Signature of Reviewer: _____
Date: _____

Place Patient label here


10-05 Revised:10/07/16