TB and Newcomer Health History

Patient Label

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			29. Organ Transplant			
11. Deafness/Ear problems/Tubes			29. Skin problems			
12. Dental Problems			30. Stroke			
13. Diabetes (sugar)			31. Suicide/thoughts/attempt			
14. Diarrhea/Constipation/Bowel Problem			32. Thyroid problems			
15. Eating of non-food items			33. Throat problems			
16. Epilepsy/Seizures			34. Tuberculosis/other lung problem			
17. Feeding Problems/Special Diet			35. Vision/Eye problem			
18. Gall Bladder Problems			36. Other_____________________			

G_____P____A_____ LMP:____________ If Pregnant EDD:_________ Breastfeeding YES____ NO____ Birth Control Method_________________

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?_______________________ Quit Now Referral? YES_______NO____

Do you use other drugs? YES_____NO_____ If YES, what?____

Do you have any tattoos/body art/body piercings/traditional or tribal scars or markings? YES_____NO____ Describe:______________________

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TNF Alpha Blockers? YES___NO____ List any other medications: ____

Do you use any traditional herbs or remedies? YES_____NO_______If YES, what and how often?_______________________________________

Current Occupation/School: ____

Do you live in house____ apartment____ mobile home_____ motel____ shelter___ other___? Number of persons living there:_______________

Signature of person completing form:____

Date:_________________