**Ortega Wellness**

**Personal Health History**

First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

Children: (how many) \_\_\_\_\_\_\_\_

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

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunizations:** (Include approximate year/age)

( ) COVID ( ) Gardasil (HPV) ( ) Hepatitis A ( ) Hepatitis B ( ) Influenza (flu) ( ) Pneumonia/Pneumovax

( ) Prevnar 13 ( ) Shingles vaccine/Zostavax ( ) Tetanus

**Past/Present Medical History:** (check all that apply to you)

( ) ADHD/ADD ( ) Diabetes Type: ( ) High cholesterol ( ) Perph. artery disease

( ) Alcohol/Drug problem ( ) Diverticulosis ( ) HIV ( ) Seizures

( ) Anemia ( ) Cancer Type: \_\_\_\_\_( ) Hypothyroidism (low) ( ) Sleep apnea

( ) Anxiety ( ) Cholelithiasis (gallstones) ( ) Hyperthyroidism (high) ( ) Stroke

( ) Arthritis ( ) Emphysema/COPD ( ) Kidney Disease ( ) STD/STI

( ) Asthma ( ) Heart attack ( ) Kidney Stones

( ) Atrial fibrillation ( ) Heart coronary artery dis. ( ) Liver Disease

( ) Autoimmune disorder ( ) Heart failure / CHF ( ) Migraines ( ) Bipolar ( ) Heart Murmur ( ) Neuropathy ( ) Blood Clots ( ) Hepatitis ( ) Osteoporosis

( ) Dementia ( ) High blood pressure ( ) Prostate issue ( ) Depression

Specify other diagnosed medical hx:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History:** Include year and age at the time of surgery

( ) Appendectomy ( ) Hernia

( ) Breast Surgery ( ) Hysterectomy Partial/Total

( ) Cardiac Bypass (CABG) ( ) Tonsillectomy

( ) Cardiac angioplasty/stent ( ) Tubal / Vasectomy

( ) Cataract Surgery ( ) Orthopedic

( ) Cholecystectomy (gallbladder removal)

( ) Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Health History**

| **Family Member** | **Alive**  **or Dead** | **Alcohol**  **abuse** | **Breast**  **cancer** | **Ovarian**  **cancer** | **Prostate cancer** | **Other**  **cancer(s)** | **Diabetes** | **Heart**  **disease** | **High**  **cholesterol** | **High Blood Pressure** | **Mental**  **illness** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mother** |  |  |  |  |  |  |  |  |  |  |  |
| **Father** |  |  |  |  |  |  |  |  |  |  |  |
| **Grandmother**  ***Mother’s Side*** |  |  |  |  |  |  |  |  |  |  |  |
| **Grandfather**  ***Mother’s Side*** |  |  |  |  |  |  |  |  |  |  |  |
| **Grandmother**  ***Father’s Side*** |  |  |  |  |  |  |  |  |  |  |  |
| **Grandfather**  ***Father’s Side*** |  |  |  |  |  |  |  |  |  |  |  |
| **Sister** |  |  |  |  |  |  |  |  |  |  |  |
| **Brother** |  |  |  |  |  |  |  |  |  |  |  |

**MEDICATIONS: List prescribed and over-the-counter medications**

| **DRUG NAME:** | **DOSE & DIRECTIONS:** | **REASON:** |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**ALLERGIES/ REACTIONS to Medications:**

| **DRUG NAME:** | **REACTION/ COMMENTS:** |
| --- | --- |
|  |  |
|  |  |
|  |  |
| **LIST ANY FOOD OR ENVIRONMENTAL ALLERGIES AND REACTIONS:** | |
|  | |

Tobacco:

( ) Never Smoker

( ) Former Smoker

( ) Light Tobacco Smoker

( ) Heavy Tobacco Smoker

( ) Cigar Use

( ) Vape Use

How often do you have a drink containing alcohol:

( ) Never

( ) Monthly or less

( ) 2-4 times per month

( ) 2-3 times per week

( ) 4 or more times per week

How many standard drinks containing alcohol do you have on a typical day?

( ) 0 ( ) 5 or 6

( ) 1 or 2 ( ) 7 to 9

( ) 3 or 4 ( ) 10 or more

How often do you have 6 or more drinks on 1 occasion?

( ) Never ( ) Weekly

( ) Less than monthly ( ) Daily or almost daily

( ) Monthly or less

Have you used recreational or street drugs within the last 2 years? ( ) yes ( ) no

If yes, which drug(s): \_\_\_\_\_\_\_\_\_\_ Date last used:\_\_\_\_\_\_\_

Have you ever used recreational drugs with a needle? ( ) yes ( ) no

Do you wear your seatbelt? ( ) yes ( ) no

Do you have household smoke detectors? ( ) yes ( ) no

Do you have frequent falls? ( ) yes ( ) no

Do you feel safe at home? ( ) yes ( ) no

Do you feel safe with your partner? ( ) yes ( ) no

Are your children safe in your home? ( ) yes ( ) no

Are you experiencing verbally threatening behaviour, mental abuse, physical abuse or sexual abuse? ( ) yes ( ) no