## PHE - Medical health history

CC – What problem brings you in today? How can I help you?

HPI

1. Could you please tell me more about your problem (pain, cough etc.)?
2. Onset: When did this start? Tell me what you were doing when it started?
3. Location: Where did it start? Did it move anywhere? Is the symptom located in a specific place? Has this changed over time? Does it radiate to a specific area of the body?
4. Duration: How long does it last?
5. Frequency: How often do you have it? How frequent do you have it?
6. Quality: Can you describe the pain for me? Is it: Burning, stabbing, crashing, dull, chocking, pressure like, knife-like, pins and needles, electric?
7. Severity: How bothersome is this problem? Does it interfere with your daily activities? Does it keep you up at night?
   Please rate your pain from scale 1 to 10 with 10 being the worse pain of your life. Is the pain getting better, worse, the same?
8. Does anything make it worse?
9. Does anything make it better?
10. Do you have any additional presentations? Are there any other things that happen? Are there any associated symptoms?
11. Why today?

PMH

1. Do you have any other medical problems?
2. Did you have in past or recently any childhood diseases like – Measles, Mumps, Rubella, Chicken pox, Whooping cough, Scarlet fever, Rheumatic fever, Polio?
3. Did you have or have any adulthood conditions - hypertension, diabetes, thyroid issues, strokes, heart attacks, Hepatitis, Asthma, HIV, Seizures, Arthritis, Tuberculosis?
4. Did you have any hospitalization? When? For what? How Long? Any complications? When you were discharged was everything addressed? Any issues after the discharge?
5. Did you have any surgeries? When? For what? Any complications?

6. Did you receive any immunizations? Any reactions?
7. Did you take or are taking any medications, supplements, herbs?
8. When did you have last comprehensive exam? Full blood work? Urinalysis? Chest X-ray?
9. Do you have or had any allergies? Have you ever been tested for allergies?

FH

1. Does anybody in the immediate family (parents, grandparents, siblings, children) has similar presentation or complaints?
2. Does anybody in the immediate family has any of these conditions - cancer, diabetes, hypertension, heart disease, high cholesterol, arthritis, asthma, thyroid disease, renal diseases, atherosclerosis, stroke, seizure, headache, mental disorder, substance abuse, allergies?
3. What was age and reason of death of any of relatives?

SH

1. Do you have any difficulties with daily activities and tasks?
2. How would you describe your sexual orientation? How would you describe your gender identity? What is the sex on your original birth certificate?
3. Where were you born? How long have you lived in US? Where do you currently live
4. Do you have any partner, spouse? Do you have any children?
5. Who lives with you at home? Are there friends or family nearby? With whom do you spend your day?
6. Are you currently working? What kind of job have you had in the past? Have you ever had more than one job at a time? Tell me what that job is like for you? Do you feel secure in your job? Do you think anything at work is making you feel sick?
7. What is the highest level of school you have completed? Where did you go to school?
8. What do you do when you are not working? Can you walk me through a typical day? Do you travel?
9. Smoking History: Have they ever smoked cigarettes? If so, how many packs per day and for how many years? If they quit, when did this occur? The packs per day multiplied by the number of years gives the pack-years, a

widely accepted method for smoking quantification. Pipe, cigar and chewing tobacco use should also be noted.

10. Alcohol: Do they drink alcohol? If so, how much per day and what type of drink? Encourage them to be as specific as possible. If they do not drink daily, how much do they consume over a week or month?
11. Illicit Drug use: How many times in the past year have you used an illegal drug or used prescription medication for non-medical reasons?
12. Sexual history: To help you better I would need to ask you some questions about your sexual health and practices?
    a. Do you have any specific concerns or questions we can start with?
    b. When was last time you had intimate sexual contact? Did that contact include sexual intercourse?
    c. What are genders of your sexual partners?
    d. How many sexual partners have you had in the last 6 months? In the last 5 years? In the lifetime?
    e. What kind of sex are you having?
    f. What did you do to protect yourself form HIV and STDs?
    g. Do you have any concerns about HIV infection and AIDS?
    h. Have you ever had sexually transmitted infection?
    i. Have you ever been tested for any STDs?
    j. Do you have any plans or desires to have children?
    k. Have you experienced any trauma, violence, sexual satisfaction, sexual health concerns?
13. Spiritual history
    a. What is your faith or belief?
    b. Do you consider yourself spiritual or religious?
    c. What things do you believe in that gives you life meaning?
    d. Is it important in your life?
    e. Are you part of spiritual or religious organization?

ROS

1. General: Did you have any recent - Weight Loss, Weight gain, Fatigue, Difficulty sleeping, Feeling well (or poorly) in general, Recent medical evaluations or treatments, Chronic pain, Fevers, chills, sweats?

2. Skin: Did you have any recent - Hair Loss, Skin disease, Skin eruptions/rashes, Growths, Sores that grow and/or don't heal, Lesions changing in size, shape, or color, Itching?
3. HEENT
    a. Head: Did you have any recent or past headaches, head traumas,
    b. Eyes.: Did you have or have any recent - Chronic or past eye disorders? Decrease/change in vision or blurriness? With or without pain? Double vision? Eye discharge? Excessive tearing, Flashing lights, Glaucoma, Cataracts, Red Eye? Comprehensive eye exam?
    c. Ears: Did you have any past or recent Ear discharge, Hearing change, Tinnitus, Vertigo, Earaches, Infections?
    d. Nose: Did you have any past or recent Nasal discharge, Epistaxis (Nose bleeds), Frequent colds, Sinus trouble?
    e. Throat: Did you have any past or recent – Gum and teeth problems, Bleeding gums, Dentures, Sore tongue, Sore throat, Hoarseness?
4. Neck: Did you have any past or recent – Swollen glands, Goiter, Neck lumps, Neck pain, Stiffness, Decreased ROM
5. Breasts: Did you have any past or recent – Lumos, Pain, Nipple discharge, Discomfort, Self-examination, Comprehensive examination?
6. Respiratory system: Did you have any recent or past Comprehensive pulmonary exam, Chronic or past pulmonary disorders, Shortness of breath, Chest pain, Cough, Hemoptysis (coughing up blood), Wheezing, Snoring or stop breathing?
7. Cardiovascular: Did you have any past or recent Chronic cardiovascular disorders, Chest pain (CP) or pressure, Shortness of breath, Orthopnea (short of breath lying down), Paroxysmal Nocturnal Dyspnea (PND), Lower extremity edema, Sudden loss of consciousness (syncope), Sense of rapid or irregular heartbeat, palpitations?
8. Peripheral vascular: Calf/leg pain/cramps w/ambulation, Wounds/ulcers in feet, Difficult/slow to healing, Cold extremities?
9. Gastrointestinal: Did you have any past or recent - Comprehensive GI exam, Chronic or past GI disorders, Heart burn/sub-sternal burning, Abdominal pain, Difficulty swallowing, Pain upon swallowing, Nausea or Vomiting, Abdominal swelling or distention, Jaundice (yellowish coloration of skin),

Vomiting blood (hematemesis), Black/tarry stools, Bloody stools, Constipation, Diarrhea?

10. Genitourinary: Did you have any past or recent - Chronic or past GU disorders, Hematuria (Blood in urine), Burning with urination, Nocturia(Urination at night, Incontinence (unintentional loss of urine), Urgency, Frequency, Incomplete emptying, Hesitancy, Decreased force of stream, Need to void soon after urinating, Erectile Dysfunction, Testicular pain, Testicular swelling, mass, Penile Ulcers or Growths, Fertility problems?
11. Musculoskeletal: Did you have any past or recent – Muscle or joint pain, stiffness, Arthritis, Dislocations, Fractures, Other traumas, Gout, Low back pain?
12. Psychiatric: Did you have any past or recent - Known mental health disorder? Depression or depressive thought, Anxiety, Memory issues, Confusion?
13. Neurologic: Did you have any past or recent - Comprehensive neuro exam, Sudden loss of neurological function, Abrupt loss/change in level of consciousness, Seizure activity, Numbness, Weakness, Dizziness, Balance problems, Headache?
14. Hematology: Did you have any past or recent – Anemias, Easy bruising, and bleeding?
15. Endocrine: Did you have any past or recent - Known Endocrine disorder, Polyuria, polydipsia, polyphagia, Fatigue, Weight loss, Weight gain, Heat intolerance, Cold intolerance, Stress intolerance?