HEALTH HISTORY: Please mark (X) if you (Self) or any immediate family member (Fam) ever had any of the following:

ILLNESS	Self	Fam	If Family, Who?	ILLNESS	Self	Fam	If Family, Who?
Stroke (TIA) or (CVA)				Bladder/ Kidney Problems			
Heart Problems				Liver Disease/ Hepatitis			
Heart Failure (CHF)				Arthritis/ Back Pain			
High Blood Pressure				Ulcers/ Reflux			
Epilepsy/ Seizures				Diabetes			
Asthma				Colon Disease (IBS, Diverticulitis)			
Emphysema (COPD)				Mental Illness (Anxiety, Depression)			
Anemia or Bleeding Disorder				Recurrent or Chronic Infectious Diseases			
High Cholesterol				Eating Disorders (Anorexia)			
Thyroid Problems				Sleep Disorders			
Tuberculosis (TB)				Other: (please list)			
Cancer (list type)				Surgery (please list) Self ONLY			

Employment: ❑ Retired ❑ Full-Time ❑ Part-Time Disabled: ❑ No ❑ Yes _____ (year)

Martial Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed Home: ❑ 1-Story ❑ 2-Story Children in home: _____

Immunizations: ❑ Up to Date ❑ Unknown _____

Learning Barriers: ❑ None ❑ Hard of Hearing ❑ Hearing Aid ❑ Glasses/Contacts ❑ Dentures ❑ Other _____

Do you or did you ever smoke? ❑ No ❑ Yes Date quit? _____ How many packs/day?_____

How many years have you smoked? _____

Do you drink alcohol? ❑ No ❑ Yes How many drinks/day?_____

Do you use recreational drugs? ❑ No ❑ Yes What? _____

Have you ever had a blood transfusion? ❑ No ❑ Yes When? _____

Is there any additional information you would like to have regarding your health care? ❑ No ❑ Yes (what topics)

_____

_____

_____

RN Signature _____ Date_____ Time _____

Grady Memorial Hospital
OhioHealth

DT140

PATIENT IDENTIFICATION LABEL

GRADY MEMORIAL HOSPITAL

HEALTH HISTORY / SUMMARY LIST

5094 (6/24/2013)