Prepare for your visit

This form will help you prepare for your upcoming visit with your doctor. You can complete it on your computer (Mac or PC) and e-mail it to your doctor ahead of time. Or, you may fill it out on the computer, print it, and bring it with you to your visit. Instructions for completing and saving this form vary depending on whether you use a Mac or a PC.

Caution: When using a public computer (library, Internet cafe, etc.), saving your entries may make it possible for others to view your information. To avoid this, never save your personal information on a public computer.

How to fill out the form

Step 1

PC users: Use your mouse to position your cursor over the field you would like to complete. Click inside the field and when your cursor appears, type your response to each question using your keyboard.

Mac users: See **Step 2**.

Step 2

PC users:

Please use your native browser (Internet Explorer):

➡ **Click the Save button at the bottom of the form** to create a copy of your completed form as a PDF document on your computer. In the dialog box that opens, select the folder where you want to store this file and click "Save." Do not save the file under a new name.

Remember where you save this file. To print the form, select the **Print button** at the bottom of the form.

Mac users:

Please use your native browser (Safari):

➡ From the File menu select **Save as** to create a copy of your uncompleted form as a PDF document on your computer. In the dialog box that opens, select the folder where you want to store this file and click "Save." Do not save the file under a new name. **Remember where you save this file.**

➡ **To fill out the form,** open it with Acrobat Reader. Then, use your mouse to position your cursor over the field you would like to complete. Click inside the field and when your cursor appears, type your response to each question using your keyboard. Save your file under the same name.

➡ To print the form, select the **Print dialog box** from the File menu on Acrobat.

Step 3

PC users, when you are ready to send this form, click the **E-mail Form** button, which will launch your browser. Then log in to your kp.org account. **Mac users**, please launch your browser and login to your kp.org account.

➡ Once your login is successful, create a message to your doctor.

➡ Attach the completed form by clicking on **Browse** in the **Attach File** section below your message. In the dialog box that opens on your screen, locate the form you saved on your computer in Step 2. Click on the file name to select it and click Open. This will select the form to be attached to your message. Click **Send** to send the message to your doctor.

DONE! You can now close the browser.

KAISER PERMANENTE®

Member Health History

Name _____ Today's Date _____

Medical Record No _____

Place of birth _____ Your Occupation _____

Marital Status _____ Your Partner's Occupation _____

If you have children, what are their ages? _____

Who lives with you or do you live alone? _____

What are your hobbies? _____

PERSONAL MEDICAL HISTORY

			Enter any comments below
Allergy	☐ YES	☐ NO	
Asthma	☐ YES	☐ NO	
COPD/Emphysema	☐ YES	☐ NO	
Atrial fibrillation	☐ YES	☐ NO	
Heart murmur as an adult	☐ YES	☐ NO	
Heart disease/heart attack	☐ YES	☐ NO	
Congestive heart failure	☐ YES	☐ NO	
Rheumatic fever	☐ YES	☐ NO	
High cholesterol	☐ YES	☐ NO	
High blood pressure	☐ YES	☐ NO	
History of cancer or tumor	☐ YES	☐ NO	
Thyroid condition (hypo or hyper)	☐ YES	☐ NO	
Diabetes	☐ YES	☐ NO	
Osteoporosis	☐ YES	☐ NO	
Bone fractures	☐ YES	☐ NO	
Radiation treatments to the head/neck	☐ YES	☐ NO	
Glaucoma	☐ YES	☐ NO	
Acid reflux or heartburn	☐ YES	☐ NO	
Hepatitis	☐ YES	☐ NO	
Liver Cirrhosis	☐ YES	☐ NO	
Stomach or duodenal ulcer	☐ YES	☐ NO	
Irritable bowel disease	☐ YES	☐ NO	
Colon or bowel disease (including polyps)	☐ YES	☐ NO	

PERSONAL MEDICAL HISTORY (continued)			Enter any comments below
Kidney problem (including stones)	☐ YES	☐ NO	
Gynecologic problems (including fibroids or endometriosis)	☐ YES	☐ NO	
Prostate problems	☐ YES	☐ NO	
Migraine headaches	☐ YES	☐ NO	
Stroke	☐ YES	☐ NO	
Seizures/Epilepsy	☐ YES	☐ NO	
Arthritis	☐ YES	☐ NO	
Rheumatoid Arthritis or Lupus	☐ YES	☐ NO	
Gout	☐ YES	☐ NO	
Anemia	☐ YES	☐ NO	
Blood clots	☐ YES	☐ NO	
Blood transfusion before 1992	☐ YES	☐ NO	
History of chicken pox	☐ YES	☐ NO	
Spleen removed	☐ YES	☐ NO	
History of pneumonia	☐ YES	☐ NO	
History of positive skin test for tuberculosis	☐ YES	☐ NO	
Alcohol/drug problem	☐ YES	☐ NO	
Anxiety or panic attacks	☐ YES	☐ NO	
Depression	☐ YES	☐ NO	
Bipolar disease	☐ YES	☐ NO	
Vegetarian diet	☐ YES	☐ NO	

PERSONAL SURGICAL HISTORY			Enter any comments below
Abdominal surgery	☐ YES	☐ NO	
Appendix removed	☐ YES	☐ NO	
Back surgery	☐ YES	☐ NO	
Biopsy	☐ YES	☐ NO	
Breast surgery	☐ YES	☐ NO	
Coronary bypass	☐ YES	☐ NO	
Coronary stenting	☐ YES	☐ NO	
Heart Surgery (other than bypass/stents)	☐ YES	☐ NO	
Gallbladder Removal	☐ YES	☐ NO	

PERSONAL SURGICAL HISTORY (continued)

			Enter any comments below
Hip surgery	☐ YES	☐ NO	
Hysterectomy (ovaries removed)	☐ YES	☐ NO	
Hysterectomy (ovaries left)	☐ YES	☐ NO	
Knee surgery	☐ YES	☐ NO	
Neck surgery	☐ YES	☐ NO	
Tubal ligation	☐ YES	☐ NO	
Spleen removed	☐ YES	☐ NO	
Other			

MEDICATIONS Enter name, dose and direction information

NAME	DOSE	DIRECTIONS

DRUG ALLERGIES Enter drug name and any reactions

DRUG NAME	REACTION

FAMILY HISTORY *(check all that apply)*

	NONE	MOTHER	FATHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER
Healthy	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Drug Addiction	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐
Hyperlipidemia	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐
Colon Polyp	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐
Prostate Cancer	☐	☐	☐	☐	☐	☐	☐
Alzheimer Disease	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Aortic Aneurysm	☐	☐	☐	☐	☐	☐	☐
Alcohol Problem	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐
Clotting Disorder	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Genetic Disorder	☐	☐	☐	☐	☐	☐	☐
Hemochromatosis	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐
Ovarian Cancer	☐	☐	☐	☐	☐	☐	☐
Panic Disorder	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐
Thyroid Cancer	☐	☐	☐	☐	☐	☐	☐
Thyroid Disorder	☐	☐	☐	☐	☐	☐	☐

PREVENTATIVE CARE *(indicate dates, please bring documentation with you to your visit)*

Pneumonia vaccine		Colonoscopy	
Tetanus vaccine		Pap smear	
Zoster or chickenpox vaccine		Mammogram	
		Bone density scan	

OTHER HEALTH ISSUES

Tobacco use ☐ Never ☐ YES ☐ NO
- Current smoker? ☐ YES Packs/day ____ # Years ____
- Former smoker? ☐ YES # Years smoked ____ Quit Date ____
- Other tobacco, including pipes, cigars, snuff, or chews ____

Alcohol use ☐ YES ☐ NO Type of drink ____ # of drinks /week ____

Drug use
- Do you use marijuana or recreational drugs? ☐ YES ☐ NO
- Have you ever used needles to inject drugs? ☐ YES ☐ NO

Sexual Activity
- Are you sexually active? ☐ YES ☐ NO
- Do you have sex with: ☐ Men ☐ Women ☐ Both
- Birth control method ____

Do you have an Advance Directive for Health Care (ADHC)?	☐ YES	☐ NO
Do you have a Durable Power of Attorney for medical decision-making?	☐ YES	☐ NO
Do you have a Physician Order for Life Sustaining Therapy (POLST)?	☐ YES	☐ NO

PC users, use button below. Mac users, refer to instructions.

Print | Save | Submit Completed Form