RURAL/FRONTIER WOMEN'S HEALTH COORDINATING CENTERS

UTAH NAVAJO HEALTH SYSTEM, INC.
RURAL/FRONTIER COORDINATING HEALTH CENTER
Women's Health-Sáanii bits' iis baa a'ha yáá
Sponsored by the U.S. Department of Health and Human Services

Name____

Birth Date____________________________________

Home phone__________________ Work phone_________________ Email______________________________

Please list a contact person and telephone number, in case of emergency:

____

Where have you been receiving your medical care?

Name of Physician:____

Address:____

Street Address City State Zip Code

Do you use traditional Native Healing? If so, check which ones you use. NAC ☐ Traditional ☐ (list what type) _____________________

____

Are you currently: ☐ Married ☐ Divorced/Separated ☐ Single ☐ Living with Significant Other ☐ Widow

How many are living in your home?_______________

Do you have a problem paying for medical care? Yes ☐ No ☐

Do you have health insurance? ☐ None ☐ Private ☐ Medicare ☐ Medicaid ☐ IHS ☐ Other

PAST MEDICAL HISTORY: Please circle Yes or No for any illnesses that you have had:

AIDS/HIV	Yes	No	Kidney Disease	Yes	No
Anemia	Yes	No	Liver Disease	Yes	No
Arthritis	Yes	No	Lung Disease	Yes	No
Asthma/Bronchitis/Emphysema	Yes	No	Measles	Yes	No
Bleeding/Bruising easily	Yes	No	Mumps	Yes	No
Blood Disorder	Yes	No	Mental Illness	Yes	No
Cancer (type)	Yes	No	Pneumonia/Pleurisy	Yes	No
Crohn's/colitis	Yes	No	Sinus Problems	Yes	No
Depression	Yes	No	Skin Disease	Yes	No
Diabetes	Yes	No	Stroke	Yes	No
Drug/Alcohol dependency	Yes	No	Rheumatic Fever	Yes	No
Eating Disorder	Yes	No	Stomach Ulcers	Yes	No
Epilepsy/Seizures	Yes	No	Thyroid Disease	Yes	No
Gout	Yes	No	Tuberculosis	Yes	No
Hay Fever	Yes	No	Depression or Anxiety	Yes	No
Hearing Problems	Yes	No	Other	Yes	No
Hepatitis	Yes	No		Yes	No
High Blood Pressure	Yes	No		Yes	No
Immune Disorders	Yes	No		Yes	No
Intestinal Problems	Yes	No		Yes	No

Have you ever been hospitalized or had any surgeries ☐Yes ☐No If yes, please list the date(s) and reason(s):

____

____

Please list any medications you take, including prescription drugs, over-the-counter drugs, eye drops, vitamins, minerals, and herbs:

Name of Medication (s), herbs or vitamins   Dose or Strength   How often do you take it?

____
____
____
____
____
____

Have you ever had an allergic reaction to a medication(s)? ☐Yes ☐No If yes, which medication(s)?

Medication   Reaction

____
____

Other Allergies (foods or other substances)____

FAMILY HISTORY: Have any members of your family, (including grandparents, parents, siblings, or children), had any of the following?

Problem	Circle Yes or No		Family Relationship
Alcoholism / Substance Abuse	Yes	No	
ALS (Lou Gehrig's Disease)	Yes	No	
Alzheimer's / Dementia	Yes	No	
Anemia / Bleeding Problems	Yes	No	
Cancer (Breast, Ovarian, Colon, Other)	Yes	No	
Depression / Other Mental Illness	Yes	No	
Diabetes	Yes	No	
Heart Disease / Angina	Yes	No	
Hepatitis / Liver Disease	Yes	No	
High Blood Pressure	Yes	No	
High Cholesterol	Yes	No	
Kidney Disease	Yes	No	
Mental Illness	Yes	No	
Migraine	Yes	No	
Osteoporosis	Yes	No	
Seizure Disorders	Yes	No	
Stroke	Yes	No	
Thyroid Disease	Yes	No	
Tuberculosis	Yes	No	
Other (Please describe)	Yes	No	

SOCIAL HISTORY: Please tell us about your lifestyle and personal habits. It is OK if you choose not to answer any of these questions.
What is your occupation____________________________________ Employer____________________________

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Sometime people have difficulty learning, understanding, or following their treatment plan. This may be due to difficulty reading, language, cultural issues,
visual or other physical problems. Do you have any such concerns? No ☐ Yes ☐
What is your primary language?___________________________
What is your highest education level in school?_____________

Do you live alone? ☐ Yes ☐ No If no, whom do you live with?________________________________

Do you follow any special diet? ☐ Yes ☐ No If yes, describe: ____

Do you have concerns about your nutrition? ☐ Yes ☐No If yes, describe: ______________________________

Do you exercise regularly? ☐Yes ☐ No If yes, describe: ____

If the answer is yes how many times of the week do you exercise___________________________________

Rate the level of stress in your life (circle) 0 1 2 3 4 5 6 7 8 9 10
No stress Very High stress

Race/ethnicity ☐ Native American ☐ Caucasian (White) ☐ Hispanic ☐ Asian American ☐ Other

Do you/have access to a car? ☐ Yes ☐ No If the answer is no, who brings you to the clinic?__________________

Do you use chewing tobacco or snuff? ☐ Yes ☐ No Do you smoke cigars or cigarettes? ☐ Yes ☐ No

If the answer is **Yes**, answer the questions below:			If the answer is **No**, answer the questions below:		
How many years have you smoked?			Have you smoked in the past?	Yes	No
How many packs per day do you smoke?			How many packs per day did you smoke?		
Are you interested in quitting?	Yes	No	When did you quit?		

Do you drink alcohol? ☐ Yes ☐ No If yes, please answer the questions in the box:

During the last week, on how many days have you had a drink?		
On days when you had a drink, how many drinks (beer, wine, liquor) did you have?		
Have you ever felt that you ought to cut down on your drinking?	Yes	No
Have people criticized your drinking?	Yes	No
Have you ever felt bad or guilty about your drinking?	Yes	No
Have you ever had to have a drink first thing in the morning to steady your nerves or get rid of a hangover?	Yes	No
Have you ever had blackouts or memory loss?	Yes	No

Do you use or take any drugs such as marijuana, cocaine, stimulants, or sedatives? ☐Yes ☐No

If yes, describe: ____________________________ Have you ever injected any drugs? ☐Yes ☐No

Risk factors for infection with HIV, the AIDS virus, include anal intercourse or vaginal intercourse with multiple partners, intravenous drug use, hemophilia, past history of a blood transfusion between 1979-1985, and sexual contact with an HIV-positive individual or other person with these risk factors. If you have any of these risk factors, or are interested in being tested for HIV infection, please discuss this with your health care provider.

How old were you when you had your first menstrual period? Age___________
Do you still have periods? ☐ No ☐ Yes
If the answer is yes are your periods: (Check all that apply)
☐ Regular ☐ Irregular ☐ Painful/cramps
Days of period__________ Length of cycle__________
First day of your last period_______________
Number of : Pregnancies ____ Miscarriages ____ Abortions ______ Live births _______

Do you currently use any form of birth control? ☐ No ☐ Yes
If yes, please state type that is used_______________________
Have you ever been on hormone replacement? ☐ No ☐ Yes
If yes, give dates and type____________________________________

Do you have problems with: ☐ Vaginal discharge ☐ Hot flashes ☐ Vaginal dryness ☐ Sexual problems

N

REVIEW OF SYSTEMS:

Have you experienced any of the following **in the past 3-6 months**? Please check the box.

☐	Change of health	☐	Nausea/vomiting	☐	Urine leakage with exercise	☐	Leg pain	☐	Rashes/skin problems
☐	Weight changes	☐	Peptic ulcer	☐	Painful urination	☐	Varicose veins/phlebitis	☐	
☐	Asthma/Wheezing	☐	Abdominal pain	☐	Recurrent urinary tract infections	☐	Swollen ankles//hands	☐	
☐	Heartburn	☐	Jaundice/Hepatitis	☐	Blood in urine	☐	Numbness	☐	
☐	Sore throat	☐	Diarrhea	☐	Confusion	☐	Joint/muscle stiffness/pain/weakness	☐	
☐	Hoarseness	☐	Constipation	☐	Coughing up blood	☐		☐	
☐	Difficulty swallowing	☐	Diverticulosis	☐	Chronic cough	☐	Memory loss	☐	
☐	Sinus problems	☐	Shortness of breath on exertion	☐	Hair loss	☐	Tremor/hands shaking	☐	
☐	Pain or irritation in eye(s)	☐	Bloody/tarry stools	☐	Bruise easily	☐	Neck/Back pain	☐	
☐	Change in hearing/ringing	☐	Hemorrhoids	☐	Chest pain	☐	Bone fracture	☐	
☐	Vision problems	☐	Hernia	☐	High blood pressure	☐	Headaches	☐	
☐	Problems with teeth/gums	☐	Frequent urination	☐	Irregular heart/palpitations	☐	Recurrent fevers or chills	☐	
☐	Numbness/tingling	☐	Headaches	☐	Delayed healing	☐	Difficulty sleeping	☐	

Have you ever had a mammogram? ☐ No ☐ Yes
If yes date_____________ where____________

Have you had an abnormal mammogram? ☐ No ☐ Yes
If yes date_____________ results____________________

When was your last PAP Smear? Date__________________

Have you ever had an abnormal PAP Smear? ☐ No ☐ Yes
If yes, please give date____________ treatment_____________

Have you had a Dexiscan? (test to check for bone density) ☐ No ☐ Yes
If yes, please give date__________________

Have you ever felt threatened or hurt by someone?	Yes	No
During the past month, have you felt "down" or depressed ?	Yes	No
Do you have trouble finding pleasure in things you used to enjoy?	Yes	No
Have you ever been so sad that you thought about hurting yourself?	Yes	No

If you are older than age 65 or have any chronic medical condition(s) please answer the following:

Do you have any difficulty bathing or dressing yourself?	☐Yes	☐ No
Do you ever lose control over your urination or bowel movements?	☐Yes	☐ No
Have you had 3 or more falls in the past year?	☐Yes	☐ No
Have you experienced any changes in your ability to do your usual activities?	☐Yes	☐ No
Are you receiving any special help at home?	☐Yes	☐ No

An Advance Health Care Directive is a document that provides instructions regarding your medical care in the event of serious medical problems. It also allows you to define who may make health care decisions for you if you are unable to make decisions for yourself. It has previously been called a "Living Will" or "Durable Power of Attorney for Health Care."

Do you have an Advance Health Care Directive?	☐Yes	☐ No
If no, would you like information about Advance Directives?	☐Yes	☐ No

What healthcare services are you interested in?

	Mammography		Retinal Eye Exam		Public Health
	Bone Density Screening		Surgeon consul		Radiation Exposure Screening
	Audiology		Nutrition/Dietician		Recreation
	Behavior Health		Pharmacy		Nerve Conduction Assessment
	Dental		Physical Therapy		Orthopedics
	Diabetes		Podiatry		Depression
	Cardiovascular		Prenatal/OB		Medicaid Outreach
	Eligibility		Ultrasound		Exercise Stress Test
	Ankle Brachial Blood Screen		Traditional Medicine		Family Planning
	Cancer Screening		Domestic Violence		Well Child Care
	Weight Loss Program		Stress Management		

Is there anything else you would like to tell or ask your provider?________________________________

____

Instructions to Provider: Your signature below indicates that you have reviewed the information contained in this questionnaire and you have reviewed the pertinent or key findings with the patient and/or family. Key findings must be summarized in your progress note; however, the questionnaire may be referenced for additional details.

Signature____ Date___________________________