PIMA COUNTY
HEALTH DEPARTMENT

Date _____/_____/_____

Medical History

Demographic Information

Name: Last: _____ First: _____ Middle Initial: ____
DOB: _____/_____/_____ Age: _____
Sex/Gender: ☐ Male ☐ Female ☐ Transgender
Marital Status: ☐Married ☐Single ☐Divorced ☐ Widowed ☐ Separated
Race: ☐ American-Indian/Alaska Native ☐ Asian ☐ Native Hawaiian / Other Pacific Islander ☐ Black/African American ☐ White ☐ Other___
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Contact Information

Address: Street_____ Apt./Unit#_____ State_____ Zip Code: _____
Phone: Home Landline: _____ Cell: _____
Email: _____
Emergency Contact: Name_____ Relationship: _____ Phone: _____

Healthcare Provider Information

Primary Care Provider: Name: _____ Specialty: _____
Office/Clinic/Hospital Name: _____Office Phone: _____Office Fax: _____

Reason for Visit: Why did you come to the TB Clinic?

_____

_____

Chief Complaint: What symptoms concern you the most?

_____

_____

Traumatic Injuries		Year

Surgeries & Invasive Procedures		
Surgeries/Procedures	Indication/Reason for Surgery/Procedure	Year

Hospitalizations		
Reason for Hospitalization	Hospital Name	Year

Allergies & Non-Allergic Adverse Reactions: Have you had adverse reactions to:

Medications (respective reaction)? :_____
Foods (respective reaction)? :_____
Environmental Agents (respective reaction)? :_____

Patient Signature: _____ Date _____/_____/_____

Review of Systems: Do you *currently* have any of the following symptoms:

Constitutional	Yes	No		Yes	No	Endocrine	Yes	No	Musculoskeletal	Yes	No
Loss of appetite	☐	☐	Frequent sneezing	☐	☐	Heat/Cold intolerance	☐	☐	Back pain	☐	☐
Unintentional weight loss	☐	☐	Mouth			Excessive thirst & drinking	☐	☐	Neck pain	☐	☐
Fatigue/Tiredness	☐	☐	Bleeding gums	☐	☐	Excessive hunger & eating	☐	☐	Muscle pain	☐	☐
Feeling sick	☐	☐	Toothache	☐	☐	Excessive sweating	☐	☐	Joint pain	☐	☐
Psychiatric			Bad breath	☐	☐	Urinary			Joint stiffness	☐	☐
Sadness	☐	☐	Throat			Painful urination	☐	☐	Joint swelling	☐	☐
Anxiety/Nervousness	☐	☐	Sore throat	☐	☐	Blood in urine	☐	☐	Generalized weakness	☐	☐
Insomnia/ Difficulty sleeping	☐	☐	Pain on swallowing	☐	☐	Urinating frequently	☐	☐	Integumentary		
Excessive sleepiness	☐	☐	Difficulty swallowing	☐	☐	Urinary incontinence	☐	☐	Lumps/bumps/masses	☐	☐
Neurologic			Hoarse voice	☐	☐	Cardiovascular			Rashes	☐	☐
Recurrent headaches	☐	☐	Respiratory			Palpitations	☐	☐	Very dry skin	☐	☐
Abnormal sensations (in feet or hands)	☐	☐	Cough	☐	☐	Lightheadedness	☐	☐	Itchiness	☐	☐
Loss of equilibrium/balance	☐	☐	Shortness of breath	☐	☐	Chest pain	☐	☐	Skin wounds due to traumatic injury	☐	☐
Recurrent drowsiness	☐	☐	Wheezing	☐	☐	Exercise intolerance	☐	☐	Skin lesions	☐	☐
Fainting	☐	☐	Chest pain when coughing or breathing	☐	☐	Swelling of both legs	☐	☐	Discoloration of skin	☐	☐
Dizziness/Vertigo	☐	☐	Blood in sputum	☐	☐	Lymphoid			Reproductive, Female		
Seizures/convulsions	☐	☐	Digestive			Enlargement of lymph nodes/glands	☐	☐	Vaginal pain	☐	☐
Weakness localized to an extremity	☐	☐	Nausea	☐	☐	Hematologic			Difficult/painful intercourse	☐	☐
Eyes			Vomiting	☐	☐	Bruising easily	☐	☐	Vaginal discharge	☐	☐
Changes in vision	☐	☐	Dry heaves	☐	☐	Immunologic			Vaginal bleeding irregularities	☐	☐
Eye pain	☐	☐	Heartburn/Reflux	☐	☐	Fevers	☐	☐	Reproductive, Male		
Double vision	☐	☐	Vomiting blood	☐	☐	Night sweats	☐	☐	Discharge of fluid through penis	☐	☐
Ears			Indigestion	☐	☐	Chills	☐	☐			
Ear ache	☐	☐	Abdominal cramping	☐	☐	Shaking with chills	☐	☐			
Hearing loss	☐	☐	Abdominal pain	☐	☐						
Congestion in ear(s)	☐	☐	Constipation	☐	☐						
Ringing of ear(s)	☐	☐	Diarrhea	☐	☐						
Nose			Dark stools	☐	☐						
Runny nose	☐	☐	Blood in stool	☐	☐						
Sinus/facial pain	☐	☐									

Patient Signature: _____ Date _____/_____/_____

Personal & Family Medical History: Do you, or any family member, have, or ever had, any of the following conditions?

	Patient			Family Member				Patient			Family Member		
	Current	Past	Never	No	Yes	Who		Current	Past	Never	No	Yes	Who
Psychiatric							**Urinary**						
Depression	☐	☐	☐	☐	☐		Renal failure	☐	☐	☐	☐	☐	
Anxiety disorder	☐	☐	☐	☐	☐		**Cardiovascular**						
Neurologic							Heart disease	☐	☐	☐	☐	☐	
Epilepsy/Seizures	☐	☐	☐	☐	☐		Hypertension	☐	☐	☐	☐	☐	
Migraines	☐	☐	☐	☐	☐		**Lymphoid**						
Eyes							Lymphadenitis (lymph node disease)	☐	☐	☐	☐	☐	
Vision loss	☐	☐	☐	☐	☐		**Hematologic**						
Ears							Leukemia/ Lymphoma	☐	☐	☐	☐	☐	
Hearing loss	☐	☐	☐	☐	☐		**Immunologic**						
Nose							HIV/AIDS	☐	☐	☐	☐	☐	
Allergic rhinitis	☐	☐	☐	☐	☐		**Musculoskeletal**						
Chronic rhinosinusitis	☐	☐	☐	☐	☐		Arthritis	☐	☐	☐	☐	☐	
Respiratory							Rheumatologic disease	☐	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐	☐		**Integumentary**						
Coccidioidomycosis (Valley Fever)	☐	☐	☐	☐	☐		Psoriasis	☐	☐	☐	☐	☐	
Chronic obstruction pulmonary disease (COPD)	☐	☐	☐	☐	☐		Atopic dermatitis/eczema	☐	☐	☐	☐	☐	
Silicosis	☐	☐	☐	☐	☐		**Reproductive**						
Latent TB infection	☐	☐	☐	☐	☐		Pelvic inflammatory disease	☐	☐	☐	☐	☐	
Active Pulmonary TB disease	☐	☐	☐	☐	☐		Miscarriages	☐	☐	☐	☐	☐	
Digestive							**Other**						
Hepatitis A, B or C	☐	☐	☐	☐	☐		Cancer	☐	☐	☐	☐	☐	
Gastroesophageal reflux disease (GERD)	☐	☐	☐	☐	☐		Organ transplantation	☐	☐	☐	☐	☐	
Gastritis or Peptic Ulcer	☐	☐	☐	☐	☐								
Endocrine													
Diabetes mellitus	☐	☐	☐	☐	☐								
Thyroid disease	☐	☐	☐	☐	☐								

Patient Signature: _____ Date _____/_____/_____

Current Medications: Please list any medications that you are now taking. Include non-prescription (over-the-counter) medications, dietary supplements (vitamins & minerals), and alternative & complementary medications (e.g., medicinal herbs).		
Name of Medication	Dose (strength & number of pills per day)	Date Started

Immunizations/Vaccinations
Bacille Calmette-Guerin (BCG) vaccine (for tuberculosis): ☐No ☐ Yes (Year Received:)
Pneumococcal vaccine (for pneumonia): ☐No ☐ Yes (Year Received:)
Influenza vaccine (for flu): ☐No ☐ Yes (Year Received:)

Social History

Native/first language? ☐ English ☐ Spanish ☐ Arabic ☐ Chinese ☐ Tagalog ☐ Vietnamese ☐ French ☐ Other_____
Religious affiliation: ☐ Christian (including Catholic, Protestant) ☐ Jewish ☐ Hindu ☐ Muslim ☐ Atheist ☐ Agnostic ☐ Other Religion
How many children do you have? _____ What are their ages? _____
Who else lives in your home/household? _____
Who do you turn to for emotional support? _____
Do you have a Medical Power of Attorney? ☐ No ☐ Yes (Who? _____)
Highest level of education you have completed? ☐ Primary/Elementary ☐ Secondary/High School ☐ Undergraduate/College degree ☐ Graduate Degree
What other occupations/jobs have you had? _____
What is your current employment status? ☐Employed ☐ Unemployed ☐ Retired
What is your current occupation/job? _____

Exposure History

TB Exposure History

Have you had close contact with an adult or adolescent with confirmed or suspected pulmonary TB? ☐ No ☐ Yes (Who?_____)
Have you had contact with an adult or adolescent with chronic cough or bloody sputum? ☐ No ☐ Yes (Who?_____)

Geographic Exposure History

Place of Birth (city; country): _____ If born outside of US, Year entered US: _____
In what countries have you resided/lived? _____
Have you ever resided/worked in a refugee camp? ☐ No ☐ Yes (Country: _____)
Have you traveled to countries other than Canada, Australia, New Zealand, or a country in Europe ☐ No ☐ Yes (Country _____)
Have you been in the military, and been deployed? ☐ No ☐ Yes (Country:_____)

Congregate Setting Exposure History

Have you ever worked at a healthcare institution (hospital; urgent care; skilled nursing facility)? ☐ No ☐ Yes (Where: _____)
Have you ever worked at a long-term residential facility? ☐ No ☐ Yes (Where: _____)
Have you ever worked or been detained at a correctional institution? ☐ No ☐ Yes (Where: _____)
Have you ever worked/resided at a homeless shelter? ☐ No ☐ Yes (Where: _____) (When: _____)

Animal Exposure History

Have you had any close exposures to cattle (cows, steers, bulls, oxen)? ☐ No ☐ Yes (Where: _____)
Have you had any close exposure to elephants? ☐ No ☐ Yes (Where: _____)

Food Exposure History

Have you ever consumed unpasteurized/dairy products (e.g., milk; cheese)? ☐ No ☐ Yes (What ? _____; Where: _____)

Substance Use History

Have you ever used tobacco (cigarettes, cigars, pipes, chewing tobacco)? ☐ No ☐ Yes (Which: _____)
Do you drink alcoholic beverages (liquor, spirits): _____ ☐ No ☐ Yes (Which: _____; how many drinks per week_____)
Recreational drug use: ☐ Marijuana/Cannabis ☐ Cocaine ☐ Amphetamine/Meth/Speed ☐ Ecstasy/MDMA ☐ LSD/Acid ☐ Ketamine
Injection Drug Use: ☐No ☐ Yes (Which: _____

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