HEALTH HISTORY

The following information is very important to your health. Please take time to fully and completely fill out this important information. We are counting on you.

Patient Name_____ **Birth Date**_____ **Age**_____
Primary Care Provider_____ **Primary care provider phone number**_____
Occupation_____
What is your reason for visit? _____

Allergies To: Medicines_____
Foods_____
Seasonal_____ **Latex □ No □ Yes**

Type of birth control_____ **Date last period**_____ **Number days between period**_____
Length of period_____ **Do you bleed between periods □ No □ Yes Flow is □ light □ moderate □heavy**
Do you get cramps □ No □ Yes Do you get PMS □ No □ Yes

Past Medical History: (Circle no or yes, leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	High Blood Pressure	no	yes
Mumps	no	yes	Bladder Infection	no	yes	Hemorrhoids	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Asthma	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hives or Eczema	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	AIDs or HIV+	no	yes
Pneumonia	no	yes	Diabetes	no	yes	Infectious Mono	no	yes
Rheumatic Fever	no	yes	Cancer	no	yes	Mitral Valve Prolapse	no	yes
Heart Disease	no	yes	Polio	no	yes	Stroke	no	yes
Arthritis	no	yes	Hernia	no	yes	Hepatitis	no	yes
Sexually Transmitted			Bleeding Tendency	no	yes	Ulcer	no	yes
Infections	no	yes	Kidney Disease	no	yes			
Thyroid Disease	no	yes	Vaginal Infection	no	yes			

Any other disease (list) _____
_____

Previous Hospitalizations/Surgeries/Serious Illnesses/When
_____
_____
_____
_____
_____

Number of pregnancies/When
Vaginal_____
_____
C-section_____
Miscarriages_____
Terminations_____

Medications/Dose: (Include nonprescription & herbal supplements)_____
_____
_____

Have you have ever had a blood transfusion, when?_____

Patient Social History:

Marital status	□ Single	□ Married	□Separated	□Divorced	□Widowed
Use of alcohol	□ Never	□ Rarely	□ Moderate	□ Daily	
Use of tobacco	□ Never	□ Quit	□ Current/packs/day_____		
Use of drugs	□ Never	□ Type/frequency_____			
Use of caffeine	□ Never	□ Rarely	□ Moderate	□ Daily	
Do you exercise	□ Never	□ Rarely	□ Moderate	□ Daily	

Do you feel safe in your current living situation?_____
When was the last time anyone threatened you, physically hurt you, or forced you to have sex against your will?
_____
How old were you when you first had intercourse?_____
Are you satisfied with your current weight?_____
Have you ever had an eating disorder? (bulimia, anorexia, compulsive overeating)_____

Family Medical History:

	Age	Disease	Deceased, Cause of Death
Father			
Mother			
Brothers			
Sisters			
Spouse/other			
Children			
Grandparents			

Review of Systems: (Indicate any personal history below)

♦ **General Health**
- Good general health lately no yes
- Recent weight change no yes
- Fatigue no yes
- Headaches no yes

♦ **Eye/Ear/Nose/Throat**
- Hearing loss or ringing no yes
- Earaches or drainage no yes
- Chronic sinus problems no yes
- Nose bleeds no yes
- Mouth sores no yes
- Bleeding gums no yes
- Sore throat/voice change no yes
- Swollen glands in neck no yes

♦ **Cardiovascular**
- Heart trouble no yes
- Chest pain or angina pectoris no yes
- Shortness of breath w/walking or lying flat no yes
- Swelling of feet, ankles, hands no yes

♦ **Respiratory**
- Chronic/frequent cough no yes
- Chronic/frequent wheezing no yes

♦ **Gastrointestinal**
- Loss of appetite no yes
- Change bowel movements no yes
- Nausea or vomiting no yes
- Rectal bleeding/blood in stool no yes
- Abdominal pain no yes

♦ **Genitourinary**
- Frequent Urination no yes
- Burning/painful urination no yes
- Blood in urine no yes
- Change in force or strain when urinating no yes
- Incontinence or dribbling no yes
- Kidney stones no yes

♦ **Sexual History**
- Do you have a current partner no yes
- Sexual concerns no yes
- Pain with intercourse no yes
- Do you use condoms no yes
- Partners □ Male □ Female □ Both

♦ **Gynecology**
- Female problems no yes
- Vaginal discharge no yes
- Breast pain no yes
- Breast lump no yes
- Breast discharge no yes
- Do you do self breast exam no yes
- Date last mammogram _____
- Date of last Pap smear _____
- Have you ever had an abnormal Pap smear no yes
- Have you ever had Gardasil or the HPV vaccine no yes
- How many doses of the vaccine _____

♦ **Neurological**
- Tremors no yes
- Head injury no yes
- Light headed or dizzy no yes
- Convulsions or seizures no yes

♦ **Muscle/Joint**
- Pain no yes
- Stiffness or swelling no yes

♦ **Skin**
- Skin become dryer no yes
- Change in moles no yes

♦ **Psychiatric**
- Memory loss no yes
- Confusion no yes
- Depression no yes
- Insomnia no yes
- Anxiety no yes

♦ **Endocrine**
- Excessive thirst no yes
- Excessive hunger no yes
- Heat/cold tolerance no yes

♦ **Hematologic/Lymphatic**
- Slow heal after cuts no yes
- Bleed/bruise easily no yes
- Anemia no yes
- Phlebitis no yes
- Past transfusion no yes
- Enlarged glands no yes

♦ **Other**
- Varicose veins no yes
- Did you ever have a bone density screen no yes

What questions do you have today?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of Patient, Parent or Guardian Date

_____ _____
Signature of Provider Date