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

Current 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 If so, what symptoms? _____
Age you started menstrual cycle _____ **Age of menopause**_____

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
_____
_____
_____
_____
_____

# of pregnancies/Date of Delivery/Complications
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	□Partner
Live with:_____						
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	□ Sporadic	□ Regular		

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)_____

(OVER)

Family Medical History (Please include Breast, Colon, Ovarian, Uterine Cancers and Blood Clotting Disorders):

	Age	Disease	Deceased, Cause of Death
Father			
Mother			
Brothers			
Sisters			
Children			
Grandparents:			
Paternal GF			
Paternal GM			
Maternal GF			
Maternal GM			

Review of Systems: (Indicate any medical conditions within the past month)

♦ **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

Sexual Preference
□ 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 understand any changes will be made in the form of an addendum. 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