

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 Infections	no	yes	Bleeding Tendency	no	yes	Ulcer	no	yes
Thyroid Disease	no	yes	Kidney Disease	no	yes			
Any other disease (list) _____			Vaginal Infection	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses/When

Number of pregnancies/When

Vaginal _____
C-section _____
Miscarriages _____
Terminations _____

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

Have you 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)

<p>◆ General Health</p> <p>Good general health lately no yes</p> <p>Recent weight change no yes</p> <p>Fatigue no yes</p> <p>Headaches no yes</p>	<p>◆ Genitourinary</p> <p>Frequent Urination no yes</p> <p>Burning/painful urination no yes</p> <p>Blood in urine no yes</p> <p>Change in force or strain when urinating no yes</p> <p>Incontinence or dribbling no yes</p> <p>Kidney stones no yes</p>	<p>◆ Muscle/Joint</p> <p>Pain no yes</p> <p>Stiffness or swelling no yes</p>
<p>◆ Eye/Ear/Nose/Throat</p> <p>Hearing loss or ringing no yes</p> <p>Earaches or drainage no yes</p> <p>Chronic sinus problems no yes</p> <p>Nose bleeds no yes</p> <p>Mouth sores no yes</p> <p>Bleeding gums no yes</p> <p>Sore throat/voice change no yes</p> <p>Swollen glands in neck no yes</p>	<p>◆ Sexual History</p> <p>Do you have a current partner no yes</p> <p>Sexual concerns no yes</p> <p>Pain with intercourse no yes</p> <p>Do you use condoms no yes</p> <p>Partners <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both</p>	<p>◆ Skin</p> <p>Skin become dryer no yes</p> <p>Change in moles no yes</p>
<p>◆ Cardiovascular</p> <p>Heart trouble no yes</p> <p>Chest pain or angina pectoris no yes</p> <p>Shortness of breath w/walking or lying flat no yes</p> <p>Swelling of feet, ankles, hands no yes</p>	<p>◆ Gynecology</p> <p>Female problems no yes</p> <p>Vaginal discharge no yes</p> <p>Breast pain no yes</p> <p>Breast lump no yes</p> <p>Breast discharge no yes</p> <p>Do you do self breast exam no yes</p> <p>Date last mammogram _____</p> <p>Date of last Pap smear _____</p> <p>Have you ever had an abnormal Pap smear no yes</p> <p>Have you ever had Gardasil or the HPV vaccine no yes</p> <p>How many doses of the vaccine _____</p>	<p>◆ Psychiatric</p> <p>Memory loss no yes</p> <p>Confusion no yes</p> <p>Depression no yes</p> <p>Insomnia no yes</p> <p>Anxiety no yes</p>
<p>◆ Respiratory</p> <p>Chronic/frequent cough no yes</p> <p>Chronic/frequent wheezing no yes</p>	<p>◆ Neurological</p> <p>Tremors no yes</p> <p>Head injury no yes</p> <p>Light headed or dizzy no yes</p> <p>Convulsions or seizures no yes</p>	<p>◆ Endocrine</p> <p>Excessive thirst no yes</p> <p>Excessive hunger no yes</p> <p>Heat/cold tolerance no yes</p>
<p>◆ Gastrointestinal</p> <p>Loss of appetite no yes</p> <p>Change bowel movements no yes</p> <p>Nausea or vomiting no yes</p> <p>Rectal bleeding/blood in stool no yes</p> <p>Abdominal pain no yes</p>		<p>◆ Hematologic/Lymphatic</p> <p>Slow heal after cuts no yes</p> <p>Bleed/bruise easily no yes</p> <p>Anemia no yes</p> <p>Phlebitis no yes</p> <p>Past transfusion no yes</p> <p>Enlarged glands no yes</p>
		<p>◆ Other</p> <p>Varicose veins no yes</p> <p>Did you ever have a bone density screen no yes</p>

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