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 _____ **Preferred Name** _____ **Preferred Pronouns** _____
Birth Date _____ **Age** _____ **Gender Identity** _____ **Sex assigned at birth** ▫ Female ▫ Male
Primary Care Provider _____ **Primary Care Provider Phone Number**_____
Occupation _____
Reason for your visit _____

Allergies To: **Medicines** _____
Foods _____
Seasonal/Environment _____ **Latex** ▫ No ▫ Yes

Medications/Dose (include non-prescription & herbal supplements)

_____
_____

Menstrual History
Type of birth control _____ Date of last period_____
Number days between periods _____ Length of period _____ Flow is ▫ light ▫ moderate ▫heavy
Do you bleed between periods ▫ No ▫ Yes Age of first period _____ Age of menopause _____
Do you get cramps ▫ No ▫ Yes Do you get PMS ▫ No ▫ Yes, what symptoms? _____

Health Maintenance
Last Pap Smear _____ Have you ever had an abnormal Pap smear? ▫ No ▫ Yes, when? _____
Last Mammogram _____ Last Colonoscopy _____ Last Bone Density Test _____
Have you ever had Gardasil or HPV vaccine? ▫ No ▫ Yes How many doses? _____
Have you had a Covid vaccine? ▫ No ▫ Yes How many doses? _____

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

ADHD	No Yes	Epilepsy/Seizures	No Yes	Lupus	No Yes
Anemia	No Yes	Endometriosis	No Yes	Osteoporosis/Osteopenia	No Yes
Anxiety	No Yes	Fibroids	No Yes	Pelvic Inflammatory Disease	No Yes
Arthritis	No Yes	GERD	No Yes	Polycystic Ovarian Syndrome (PCOS)	No Yes
Asthma	No Yes	Headaches/Migraines	No Yes	Psychiatric disorder	No Yes
Breast Problems	No Yes	Hernia	No Yes	Pyelonephritis	No Yes
Cancer	No Yes	Hepatitis	No Yes	Scoliosis	No Yes
Cardiovascular Disease	No Yes	Herpes Simplex Virus or Cold Sores	No Yes	Sexually Transmitted Infection	No Yes
Clotting Disorder or history of blood clot	No Yes	High Blood Pressure	No Yes	Tuberculosis	No Yes
Colon polyps	No Yes	High Cholesterol	No Yes	Thyroid Disease	No Yes
Congenital Heart Problems	No Yes	HIV/AIDS	No Yes	Urinary Tract Infections	No Yes
Covid-19 Infection	No Yes	Infertility	No Yes	Varicella (chickenpox or shingles)	No Yes
Depression	No Yes	Irritable Bowel Syndrome	No Yes		
Diabetes	No Yes	Kidney Disease	No Yes		
		Kidney Stones	No Yes		

Any other diseases _____
_____

Previous Hospitalizations, Surgeries, or Serious Illnesses (please include date)

_____
_____

Have you have ever had a blood transfusion? ▫ No ▫ Yes, when? _____

Obstetric History

	Date	Outcome (Vaginal, Cesarean, Miscarriage, Termination)	Birth Weight	Pregnancy/Delivery Complications
Pregnancy #1	_____	_____	_____	_____
Pregnancy #2	_____	_____	_____	_____
Pregnancy #3	_____	_____	_____	_____
Pregnancy #4	_____	_____	_____	_____
Pregnancy #5	_____	_____	_____	_____

Family Medical History (Please include all known history for 1st degree relatives and any cancer or clotting history for grandparents)
Do you have any family history of breast, colon, ovarian, or uterine cancers? ◻ No ◻ Yes Blood clotting disorders? ◻ No ◻ Yes

	Age	Disease	Deceased, Cause of Death
Father			
Mother			
Children			
Siblings			
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			

Social History
Relationship Status: ◻ Single ◻ Partner ◻ Married ◻ Separated ◻ Divorced ◻ Widowed
Live with: _____ Do you feel safe in your current living situation? ◻ Yes ◻ No
Any history of sexual, emotional, or physical abuse? ◻ No ◻ Yes
Use of Tobacco (cigarettes, vaping, or smokeless): ◻ Never ◻ Quit ◻ Current (amount per day) _____
Use of Alcohol: ◻ Never ◻ Rarely (monthly or less) ◻ Occasionally (2-4x/month) ◻ Moderately (2-3x/week) ◻ Daily
Use of Drugs: ◻ Never ◻ Former ◻ Current (type/frequency) _____
Use of Caffeine: ◻ Never ◻ Rarely ◻ Occasionally ◻ Moderately ◻ Daily
Do you exercise: ◻ Never ◻ Rarely ◻ Sporadically ◻ Daily
Are you satisfied with your current weight? ◻ Satisfied ◻ Neutral ◻ Unsatisfied Have you ever had an eating disorder? ◻ No ◻ Yes

Sexual History
Age of first intercourse _____ Current partners ◻ None ◻ Male ◻ Female ◻ Both Sexual preference ◻ Male ◻ Female ◻ Both
Do you have pain with intercourse? ◻ No ◻ Yes Do you use condoms? ◻ Never ◻ Rarely ◻ Sporadically ◻ Always

Review of Systems (Indicate any current issues below)

• General Health		**• Neurological**		**• Psychological**	
Good general health lately	No Yes	Tremors	No Yes	Memory loss or Confusion	No Yes
Recent weight change	No Yes	Head injury	No Yes	Depression	No Yes
Fatigue	No Yes	Lightheaded or dizzy	No Yes	Insomnia	No Yes
Headaches	No Yes	Convulsions or seizures	No Yes	Anxiety	No Yes
• Cardiovascular		**• Gynecology**		**• Endocrine**	
Heart trouble	No Yes	Vaginal discharge	No Yes	Excessive thirst	No Yes
Shortness of breath with walking or lying flat	No Yes	Breast pain	No Yes	Excessive hunger	No Yes
		Breast lump	No Yes	Heat/cold intolerance	No Yes
Swelling feet/ankles/hands	No Yes	Breast discharge	No Yes	Hot Flashes/Night Sweats	No Yes
• Respiratory				**• Skin**	
Chronic/frequent cough	No Yes			Skin has become dryer	No Yes
Chronic/frequent wheezing	No Yes			Change in moles	No Yes
• Gastrointestinal		**• Genitourinary**		**• Hematologic/Lymphatic**	
Loss of appetite	No Yes	Frequent urination	No Yes	Slow healing after cuts	No Yes
Changes in bowel habits	No Yes	Burning/pain with urination	No Yes	Bleed/bruise easily	No Yes
Nausea/vomiting	No Yes	Blood in urine	No Yes	Anemia	No Yes
Rectal bleeding/blood in stool	No Yes	Change in force or strain when urinating	No Yes	Phlebitis	No Yes
Abdominal pain	No Yes			Past transfusion	No Yes
Incontinence of stool	No Yes	Incontinence or dribbling	No Yes	Enlarged glands	No Yes

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