Health History Form

TODAY'S DATE: ____________PATIENT NAME: ___________________________DOB:______________

EMAIL: ____________________________ OCCUPATION: _______________________________________

PRIMARY CARE PHYSICIAN'S NAME: _____________________________PHONE:________________

PHARMACY NAME: _________________________PHONE:_________________ZIP:_________________

REASON FOR VISIT: ( ) ANNUAL GYN ( ) OBSTETRIC FIRST VISIT

( ) GYN PROBLEM VISIT /DESCRIBE PROBLEM:____

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MEDICAL HISTORY: (ANSWER ALL THAT APPLY)

Last Colonoscopy: Date: ________________ Result: Normal Abnormal

Last Dexa Scan: Date: ________________ Result: Normal Abnormal

Last Mammogram: Date: ________________ Result: Normal Abnormal

Last PAP Smear: Date: ________________ Result: Normal Abnormal

Gardasil Injections: ( ) NO ( ) YES How many injections: ______

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Major Illnesses (Answer all boxes that apply):

	YES	NO		YES	NO
Abnormal PAP			Hepatitis: A B C		
Anemia			High Cholesterol		
Anxiety			Hypertension		
Arthritis			Interstitial Cystitis		
Asthma			Irritable Bowel Syndrome (IBS)		
Blood Clots			Jaundice		
Breast Cancer			Migraines: w. aura w.o aura		
Cancer: Type: _________________			Osteopenia		
Chronic Lung Disease			Osteoporosis		
Deep Vein Thrombosis			Seizures: petit or grand		
Depression			Sexually Transmitted Disease		
Diabetes: Type I or II			Stroke		
Fractures			Tuberculosis (TB)		
Fibroids			Thyroid Disease		
Genital Warts			Ulcers		

Please add any additional information:

____

Past Surgical History	
Year	**Operation**

Use back of page for additional space if needed

CURRENT MEDICATIONS:
Prescription and non-prescription medicine, vitamins, home remedies, birth control pills, herbs:

Medication	Dosage (mg)	Frequency	Prescribing Physician

Drug Allergies:	**Reactions**
LATEX Allergy: ☐ No ☐ Yes	
IODINE Allergy: ☐ No ☐ Yes	

Family History: (Answer all boxes that apply and indicate which family member):

	None	Mother	Father	Brother	Sister	Grandmother (Maternal)	Grandmother (Paternal)	Grandfather (Maternal)	Grandfather (Paternal)	Aunt	Uncle
Blood Clots/ Deep Vein Thrombosis											
Breast Cancer											
Cervical Cancer											
Colon Cancer											
Diabetes											
Ovarian Cancer											
Stroke											
Uterine Cancer											
Osteoporosis											

Please add any additional information:

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GENETIC SCREENING: Includes patient, baby's father, or anyone in either family

Please check box:

	YES	NO		YES	NO
Tay-Sachs (Jewish, Cajun, French Canadian)			Sickle Cell Disease or Trait (African)		
Neural Tube Defect (Meningomyelocele, Spina Bifida, or Anencephaly)			Maternal Metabolic Disorder (Insulin- Dependent, Diabetes, PKU)		
Other inherited Genetic or Chromosomal Disorder			Mental Retardation/ Autism * If yes, was person tested for Fragile X		
Thalassemia (Italian, Greek, Mediterranean, or Asian Background)			Medications/ Street Drugs/ Alcohol since last menstrual period * If yes, agent (s)		
Hemophilia			Muscular Dystrophy		
Cystic Fibrosis			Huntington Chorea		
Down Syndrome			Congenital Heart Defect		
Patient or baby's father had a child with birth defects not listed above			Recurrent pregnancy loss or a stillbirth		

GYNECOLOGY: if menopausal – proceed to next section

Date of Last Menstrual Period: __________ What age did you have your first period: ____

How many days does your period last: ________ How many days between periods: _____

Menstrual Flow: ( ) Light ( ) Moderate ( ) Heavy

Any clots?: ( ) YES ( ) NO Breakthrough bleeding?: ( ) YES ( ) NO

What method of birth control do you use?: ________________________________

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MENOPAUSE:

What age did you become menopausal?____

Are you on hormone replacement therapy? ( ) YES ( ) NO

Have you experience any vaginal bleeding this year? ( ) YES ( ) NO

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OBSTETRICS: (Answer all boxes that apply):

Full term pregnancies	
Premature births	
Miscarriages	
Ectopic Pregnancies	
Living Children	
Abortions induced	
Total Number of Pregnancies	

No.	Birth Date	# of weeks at Delivery	Sex M/F	Birth Weight	Delivery Type Vag/ C-Section	Complications	Location of Delivery
1							
2							
3							
4							
5							
6							

SOCIAL HISTORY

Marital Status	Married _____ Divorced _____ Domestic Partner _____ Single _____ Widowed _____
Sexual Activity	Are you sexually active? Yes _____ No _____ If yes, what age did you become sexually active? ____________________ Current sexual partner (s) is/are: Male ______ Female _______Male and Female_______ Have you had more than 5 sexual partners in a lifetime? ____________ #____________ Have you ever had any sexually transmitted diseases (STDs): Yes _____ No _____ If yes, what kind? ____ Are you interested in STD testing? Yes _____ No _____
Alcohol	Do you drink alcohol? Yes _____ No _____ Social Drinker _____ How many drinks per week? Drinks per week: _________
Drug	Do you use recreational drugs: No _____ Yes _____ If yes, what kind? _____________
Tobacco	Current every day _________ Current some days ________________ Former ______________ Never________________ If current, how many cigarettes a day? _______________________

LIFE STYLE: Please circle answer and give detail if it applies

Have you been a victim of abuse or domestic violence? YES NO

Do you feel safe at home? YES NO

Do you live alone? YES NO

Do you perform self-breast exam? YES NO

Do you drink milk or consume dairy products daily? YES NO

Do you take calcium tablets? YES NO

Do you exercise? YES NO   frequency - how many times a week ____________

Are you satisfied with your weight?   YES NO

Please add any additional information:

____
____
____
____

AUTHORIZATION AND RELEASE:

I hereby certify that I have completed the above information to the best of my knowledge. I authorize, consent, request, and agree to actively participate in such services as routine assessments, the performance of diagnostic tests and procedures, care and treatment as self-referred or as ordered by my physician, his/her assistant or designees.

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Signature / Date

Please bring completed form to your appointment. If more convenient, please fax or mail the forms to the appropriate office. Please call the office to obtain their fax number and mailing address.

Thank you