

Health History Form

TODAY'S DATE: _____

PATIENT NAME: _____

AGE: _____ BIRTHDATE: _____ SS#: _____

ETHNICITY: _____ PRIMARY LANGUAGE:- _____

RACE: _____ HOME #: _____ WORK #: _____

CELL#: _____ EMAIL : _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

PHARMACY NAME: _____ PHONE: _____ ZIP: _____

REASON FOR VISIT: ANNUAL GYN VISIT FIRST OBSTETRIC VISIT
 GYN PROBLEM VISIT- DESCRIBE PROBLEM BELOW:

Past Medical History (Answer all boxes that apply):					
Previous History	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: <input type="checkbox"/> No <input type="checkbox"/> Yes- How many injections _____				
Major Illnesses (Answer all boxes that apply):					
	YES	NO		YES	NO
Anemia			Genital Warts		
Anxiety			Hepatitis/ Jaundice		
Arthritis/ Joint Pain			High Blood Pressure		
Asthma			High Cholesterol		
Blood Transfusions			IBS (Irritable Bowel Syndrome)		
Blood Clots/ Deep Vein			Interstitial Cystitis		
Breast Cancer			Migraines		
Cancer: Type:			Osteoporosis		
			Seizures		
Chronic Lung Disease			Sexually Transmitted Diseases		
Depression			Stroke		
Diabetes			Tuberculosis- TB		
Fractures			Thyroid Disease		

Fibroids			Ulcers		
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List Other Major Diseases: _____

Past Surgical History	
Year	Operation

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: <input type="checkbox"/> No <input type="checkbox"/> Yes	
IODINE Allergy: <input type="checkbox"/> No <input type="checkbox"/> Yes	

Family History											
Please indicate below significant medical problems of family members. Indicate which family members by checking the appropriate column.											
	None	Mother	Father	Brother	Sister	Grandmother (Maternal)	Grandmother (Paternal)	Grandfather (Maternal)	Grandfather (Paternal)	Aunt	Uncle
Blood Clots/ Deep Vein											
Breast Cancer											
Cervical Cancer											
Colon Cancer											
Diabetes											
Ovarian Cancer											

Stroke										
Uterine Cancer										
Genetic Screening: Includes patient, baby's father, or anyone in either family										
	YES	NO		YES	NO					
Tay-Sachs (Jewish, Cajun, French Canadian)			Sickle Cell Disease or Trait (African)							
Neural Tube Defect (Meningomyelocele, Spine 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							

Review of Systems: (Please fill out if you are experiencing any problems with today's appointment .If you do not have a current appointment with a provider ;please leave blank.)	
Constitutional	Chills _____ Loss of Appetite _____ Fever _____ Weight Gain _____ Fatigue _____ Night Sweats _____ Weight Loss _____
Eyes	Recent changes in vision _____
HENT (Head, Ears, Nose, & Throat)	Hay fever or allergies _____ Problems with teeth or gums _____ Sinus pain/ congestion _____
Breasts	Changes in Skin _____ Discharge _____ Lumps _____ Pain _____
Cardiovascular	Chest Pain _____ Palpitations _____
Respiratory	Cough _____ Shortness of breath _____ Wheezing _____
Gastrointestinal	Abdominal Pain _____ Blood in stools _____ Diarrhea _____ Nausea _____ Bloating _____ Constipation _____ Vomiting _____
Genitourinary/ Gynecological	Frequency of Urination _____ Incontinence _____ Sexual Dysfunction _____ Blood in Urine _____ Pain with Urination _____ Urgency of Urine _____ Vaginal Discharge _____ Vaginal Odor _____ Vaginal Itching _____ Pain with Intercourse _____ Decreased Sex Drive _____
Integument	Changes to existing skin lesions or moles _____ Rash _____
Neurological	Dizzy/ Lightheaded _____ Headaches _____

Psychiatric	Anxiety _____ Depression _____ Difficulty Sleeping _____
Heme-Lymphatics	Bleeding Disorder _____ Unexplained Lumps _____
Others not listed above	

Reproductive History

Gynecology	<p>If you are menopausal, skip to the next section.</p> <p>Date of Last Menstrual Period: _____</p> <p>What age did you have your first period: _____</p> <p>How many days are there from start of period to start of next period: _____ days</p> <p>How many days long does your period last: _____ days</p> <p>Menstrual Flow: Light _____ Moderate _____ Heavy _____</p> <p>On your heaviest days, how often do you change your tampon or pad: _____ hours</p> <p>Do you see large clots: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you have breakthrough bleeding between periods: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>What method of birth control do you use: _____</p>	
Menopause	<p>At what age did you become menopausal: _____</p> <p>If you have hot flashes or night sweats are they: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe</p> <p>Are you on hormone replacement therapy: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Have you had any vaginal bleeding this year? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	
Obstetrics	Total number of pregnancies	Number (s)
	Full term births	
	Premature births	
	Living children	
	Miscarriages	
	Abortions Induced	
	Ectopic 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

Occupation	What is your current occupation? _____
Marital Status	Married _____ Divorced _____ Domestic Partner _____ Single _____ Widowed _____
Sexual Activity	<p>Are you sexually active? Yes _____ No _____</p> <p>If yes, what age did you become sexually active? _____</p> <p>Current sexual partner (s) is/are: Male _____ Female _____ Male and Female _____</p> <p>Have you had more than 5 sexual partners in a lifetime? _____ # _____</p> <p>Have you ever has any sexually transmitted diseases (STDs): Yes _____ No _____</p> <p>If yes, what kind? _____</p> <p>Are you interested in having more children? _____ Method of birth : _____</p>
Alcohol Use	<p>Do you drink alcohol? Yes _____ No _____ Social Drinker _____</p> <p>How many drinks per week ? Drinks per week: _____</p>
Drug Use	Do you use recreational drugs: No _____ Yes _____, if yes, what kind? _____
Tobacco Use	<p>Cigarettes: No _____ Yes _____ Social Smoker _____ Quit _____ Date: _____</p> <p>Current Smoker: Packs per day _____ Number of years: _____</p>
Life Style	<p>Have you ever been abused or victim of domestic violence? _____</p> <p>Do you feel safe at home? _____</p> <p>Do you live alone? _____</p> <p>Do you do self breast exams: No _____ Yes _____</p> <p>Do you drink milk or eat dairy products daily: No _____ Yes _____</p> <p>Do you take calcium tablets: No _____ Yes _____</p> <p>Do you exercise: No _____ Yes _____</p> <p>* If yes, number of times per week _____</p> <p>Are you satisfied with your weight: No _____ Yes _____</p> <p>Have you adopted any children: No _____ Yes _____</p>

Patient Signature: _____

Date: _____