Health History Form

TODAY'S DATE: _____

PATIENT NAME: _____ **AGE:** _____

BIRTHDATE: _____**SS#:**_____

ADDRESS: _____

ETHNICITY: _____ **PRIMARY LANGUAGE:-**_____ **RACE:** _____

HOME #:_____ **WORK #:**_____ **CELL#:**_____

EMAIL: _____

EMERGENCY CONTACT NAME: _____ **PHONE:** _____

PRIMARY CARE PHYSICIAN'S NAME: _____**PHONE:**_____

PHARMACY NAME: _____**PHONE:**_____**ZIP:**_____

REASON FOR VISIT: ___ANNUAL GYN ___OBSTETRIC FIRST VISIT

GYN PROBLEM VISIT / DESCRIBE PROBLEM: _____

MEDICAL HISTORY: (ANSWER ALL THAT APPLY)

LAST COLONOSCOPY: __/__/__	RESULTS: NORMAL / ABNORMAL
LAST DEXA SCAN: __/__/__	RESULTS: NORMAL / ABNORMAL
LAST MAMMOGRAM: __/__/__	RESULTS: NORMAL / ABNORMAL
LAST PAP SMEAR __/__/__	RESULTS: NORMAL / ABNORMAL
GARDASIL INJECTIONS:	INJECTIONS: 1 2 3

Major Illnesses (Answer all boxes that apply):

	YES	NO		YES	NO
Abnormal Pap			GERD		
Anemia			Hepatitis		
Anxiety			High Cholesterol		
Arthritis			Hypertension		
Asthma			Interstitial Cystitis		
Blood Clots			Irritable Bowel Syndrome (IBS)		
Breast Cancer:			Jaundice		
Blood Transfusion			Migraines: Please circle: w/aura w/out aura		
Cancer: Type:			Osteopenia		
Chronic Lung Disease			Osteoporosis		
Deep Vein Thrombosis			Seizures Please circle: petit or grand		
Depression			Sexually Transmitted Diseases		
Diabetes: Please circle Type I or Type II			Stroke		
Fractures			Tuberculosis- TB		
Fibroids			Thyroid Disease		
Genital warts			Ulcers		

Please add any additional information:

_____
_____
_____
_____

Please list – 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**	

Past Surgical History	
Year	**Operation**

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											
Hypertension											

Please add any additional information:

_____

_____

_____

_____

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, 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		

Please add any additional information:

_____

_____

_____

_____

GYNECOLOGY: if menopausal – proceed to next section

Menstrual Cycle:	Date of last period ___/___/___ Age of first period _____years How many days does period last _____days How many days between periods _____days
Menstrual Flow:	Describe: _____light _____Moderate _____Heavy Any clots: ___Yes ___No Breakthrough bleeding: ___ Yes ___No
Birth Control:	Method:

MENOPAUSE:

What age did you become menopausal?

_____

Are you on hormone replacement therapy? Please circle: YES NO

Have you experience any vaginal bleeding this year? Please circle: YES NO

OBSTETRICS: (Answer all boxes that apply):

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

OBSTETRICS: continued

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							
7							
8							

SOCIAL HISTORY

Marital Status	Married _____ Divorced _____ Domestic Partner _____ Single _____ Widowed _____
Occupation	
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? _____ If an occasional smoker – please describe:_____

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.

_____

Signature / Date

Please fax or mail the completed form to your Physician's office prior to your visit. If this is not convenient, please bring completed form and arrive 15 minutes prior to your scheduled appointment time.

Thank you