

Health History Form

Name: _____ Age: _____ DOB: _____ Occupation: _____
Referred by: _____ Primary Doctor: _____
Date: _____ Reason for Visit: _____

Menstrual History

First day of last period _____ Usual duration _____ Days from start of one period to first day of the next _____

Age at first period _____ Age periods stopped (if menopausal) _____ **This column for doctor's use only**

Any bleeding between periods? Yes No

Any bleeding after intercourse Yes No

Bleeding as heavy as soaking a super pad or
tampon in an hour for several hours? Yes No

Painful periods that you take medicine for? Yes No

If you are Menopausal

At what age did you stop menstruating? _____

Have you ever taken hormones? Yes No

Are you taking hormones now? Yes No

Birth Control Current method _____

Previous methods _____

Are you planning pregnancy in the future? Yes No

Gynecologic History

Date of last Pap Smear: _____ Where: _____

Have you ever had:

An abnormal Pap Smear? Yes No

High Risk HPV? Yes No

Colposcopy (microscopic look at cervix)? Yes No

Freezing/burning of the cervix? Yes No

Herpes? Yes No

Chlamydia or Gonorrhea or PID? Yes No

Syphilis, Hep B or C, or HIV Yes No

Endometriosis? Yes No

Fibroids? Yes No

Have you ever been:

Infertile? Yes No

Do you have:

Unusual discharge, odor, or itching Yes No

Sexual History

My primary sexual partner at this time:

Male Female Both No one

How long have you been sexual with this partner _____

Do you have pain with intercourse? Yes No

Have you ever been abused sexually,
verbally, physically by anyone? Yes No

Breasts

Date of last mammogram: _____ Where: _____

Have you had breast surgery
(implants, reduction, biopsies) Yes No

Do you perform Breast Exams monthly? Yes No

Obstetrical History (include miscarriages, abortions and ectopic pregnancies) **G P SAB TOP Ectopic**

Year _____ Delivery Type (Vaginal, Cesarean, D & C,) _____

Name: _____ DOB: _____ Date: _____ Pg 2

Urologic History

This column for doctor's use only

- Blood in urine? Yes No
- Pain or discomfort on urination? Yes No
- Do you have a problem with loss of urine? Yes No

If Yes: Incontinent episodes per day? _____

- Urine loss with activity (sneezing, coughing)? Yes No
- Urgency right before you loose urine? Yes No
- Do you use pads? Yes No
- Feeling of incomplete emptying? Yes No

per day _____ # per night _____ Type _____

Surgical History

Procedure _____ Date _____ Hospital _____ Surgeon _____

Past Medical History (PMH)

Medical Conditions/Hospitalizations Date _____ Hospital _____ Doctor _____

Medications (including over the counter medicines and vitamins or supplements)

Drug _____ Dosage _____ Who Prescribed _____ For what condition _____

Allergies (reaction) _____

Family History (FH) Who _____ Age _____

- Breast Cancer Yes No
- Ovarian Cancer Yes No
- Uterine Cancer Yes No
- Colon Cancer Yes No
- Melanoma Yes No
- Blood clots in lungs/leg Yes No
- Insulin Dependent Diabetes Yes No
- Osteoporosis Yes No
- Heart Attack or Stroke before 55 Yes No

Social History (SH)

Marital status: Single Married Widowed Divorced Domestic Partnered

Occupation of Partner _____

Do you smoke? (# per day) _____ Yes No

Drink alcohol (glasses/week)? _____ Yes No

Ever use street drugs? What/When _____ Yes No

Eat 6 servings of dairy products a day or

Take 1200 mg calcium /400 IU Vit D supplement? Yes No

Perform aerobic exercise 3x per week? Yes No

Always wear your seatbelt? Bike Helmet? Yes No

Have you ever had a colonoscopy? When _____ Yes No

Bone density scan (Dexa)? When _____ Yes No

Cholesterol test? When _____ Yes No

Diabetes test? When _____ Yes No

Thyroid test? When _____ Yes No

Vitamin D Level? When _____ Yes No

Immunizations (date of last)

HPV Vaccine _____ Did you receive 3 shots? Yes No

Tetanus (Tdap) _____ Encouraged with PCP if > 10 years ago _____

Rubella _____ Discussed pregnancy implications as appropriate

Hepatitis B _____ Did you receive 3 shots? Yes No

Have you had the chicken pox? Yes No

Have you ever had a positive Tb test? Yes No

REVIEW OF SYSTEMS (ROS): Please check (X) any of the following that apply to you.

	CURRENT	PAST	This Column for Doctor's Use Only
1. Constitutional			
Sweats	_____	_____	_____
Unplanned weight loss/gain	_____	_____	_____
2. Eyes			
Vision changes	_____	_____	_____
3. ENT/Mouth			
Mouth sores	_____	_____	_____
4. Cardiovascular			
High blood pressure	_____	_____	_____
High cholesterol	_____	_____	_____
Swelling of legs	_____	_____	_____
Prosthetic heart valves or repair	_____	_____	_____
Born with Heart defects	_____	_____	_____
5. Respiratory			
Asthma/wheezing	_____	_____	_____
Tuberculosis	_____	_____	_____
6. Gastrointestinal			
Change in bowel habits	_____	_____	_____
Bloody stool	_____	_____	_____
Stomach ulcers	_____	_____	_____
Hepatitis/Liver disease	_____	_____	_____
7. Genitourinary			
Kidney stones	_____	_____	_____
Urgency/frequency	_____	_____	_____
Difficulty controlling urine	_____	_____	_____
8. Breast			
Persistent pain in breast	_____	_____	_____
Nipple discharge	_____	_____	_____
Breast lump	_____	_____	_____
9. Skin			
Change in moles/freckles	_____	_____	_____
10. Neurologic			
Migraine headaches	_____	_____	_____
11. Psychiatric			
Depression	_____	_____	_____
Anxiety	_____	_____	_____
12. Endocrine			
Heat or cold intolerance	_____	_____	_____
Abnormal thirst	_____	_____	_____
Hot flashes	_____	_____	_____
Thyroid problems	_____	_____	_____
Diabetes (even in pregnancy)	_____	_____	_____
13. Hematologic/Lymphatic			
Cuts that don't stop bleeding	_____	_____	_____
Blood clots in veins	_____	_____	_____
Blood transfusion	_____	_____	_____
Objection to blood transfusion	_____	_____	_____
14. Other _____	_____	_____	_____

Sign and Date once for each Annual Visit update

Date _____	Signature of Patient _____	_____
	Provider Signature _____	Date reviewed _____
Date _____	Signature of Patient _____	_____
	Provider Signature _____	Date reviewed _____
Date _____	Signature of Patient _____	_____
	Provider Signature _____	Date reviewed _____