Patient Health History Form

Today's Date: _____ **Name:**_____ **Date of Birth:**_____ **Age:**_____

Reason for Visit/Concerns: _____ **Primary Care Provider:** _____

Marital Status: ☐Single ☐Dating ☐Married ☐Widowed ☐Divorced **Partner's name:** _____

Occupation: _____ **Ethnicity:** _____ **Preferred Pharmacy:** _____

Medical Allergies/Reactions: _____

Current Medications/Dose (including birth control, over –the-counter medications and supplements):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Menstrual History:

How old were you when you first started your period? _____ Are you having periods? ☐ Yes ☐ No (If no, skip to ***)

First day of last period: _____ How many days is your cycle (from start of period to start of next period)? _____

How many days do you bleed? _____ On your heaviest days, how often do you change your pad/tampon? _____

Do you have irregular periods? ☐ Yes ☐ No List any problems with your periods: _____

Are you attempting pregnancy? ☐ Yes ☐ No How long have you been attempting? _____

***If you are through menopause, have you had any bleeding at all? ☐ Yes ☐ No When did your periods stop? ____

Sexual history:

Are you sexually active? ☐ Yes ☐ No Sexual preference: ☐Men ☐ Women ☐Both

Any new partners in the last year? ☐ Yes ☐ No How long have you been with your current partner? _____

Birth control method: _____ Do you want to be tested for STDs? ☐ Yes ☐ No

Date of most recent: PAP:_____ Results:_____ HPV Vaccine_____ Did you have all 3 shots? ☐ Yes ☐ No

Mammogram:_____ Colonoscopy:_____ Cholesterol check:_____ Bone density scan:_____

Gynecologic History:

- ☐ Abnormal PAP
- ☐ Colposcopy
- ☐ Laser/Cryosurgery/Freezing/ Cone Biopsy/LEEP
- ☐ Genital Sores
- ☐ Genital Warts (Condyloma)
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Trichomonas
- ☐ Syphilis
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Cervical Cancer
- ☐ Endometriosis
- ☐ Uterine Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Ovarian Cancer
- ☐ Infertility
- ☐ Sexual Problems
- ☐ Painful Intercourse
- ☐ Lack of Sexual Desire
- ☐ Uterine Fibroids
- ☐ Fibrocystic Breast
- ☐ Ovarian Cyst
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Other: _____

Pregnancy History:

Pregnancies___ Full-Term___ Pre-Term___Abortions___Miscarriages___Tubal Pregnancies___Multiple___Living___

DOB	Weeks (Mths/Wks)	# Hrs in Labor	Birth Weight	Sex	Name	Delivery Type	Hospital	Complications

Personal Medical History: Please CHECK if YOU have or have ever had:

- ☐ Acne
- ☐ Asthma
- ☐ Arthritis
- ☐ Anemia
- ☐ Blood Transfusion
- ☐ Blood clot in the leg or lung (DVT or PE)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Seizure
- ☐ Stroke
- ☐ Depression
- ☐ Diabetes
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Gallstones
- ☐ Colitis
- ☐ Ulcers
- ☐ Cancer
- ☐ Varicose Veins
- ☐ Migraines
- ☐ Recurrent Urinary Infections
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Skin Disease
- ☐ Osteoporosis
- ☐ Autoimmune Disease
- ☐ Lupus
- ☐ Excessive Hair Growth
- ☐ Recurrent yeast infections
- ☐ Bacterial Vaginosis

If you were born before 1972, did your mother take Diethylstilbestrol (DES) when pregnant with you? ☐ Yes ☐ No ☐ Unknown

List any other significant medical history; please provide date and relevant comments: _____
_____

Surgical History: Please list surgery and date:

_____ _____ _____
_____ _____ _____

Family Medical History: ☐ Check if you were adopted and do not know your family history

Please state which relatives have had the following and their age at diagnosis:

- ☐ Breast Cancer_____
- ☐ Ovarian Cancer_____
- ☐ Uterine Cancer_____
- ☐ Colon Cancer_____
- ☐ Other Cancer_____
- ☐ Heart Attack_____
- ☐ High Blood Pressure_____
- ☐ Deep Vein Thrombosis_____
- ☐ Stroke _____
- ☐ Diabetes _____
- ☐ Thyroid Disease _____
- ☐ Osteoporosis _____
- ☐ Birth Defects_____
- ☐ Other_____

Health Habits:

Have you used tobacco? ☐ Yes ☐ No Amount per day:_____ How long:_____ Plan to quit? ☐ Yes ☐ No

Alcohol use? ☐ Yes ☐ No Drinks per week: _____ Quit date:_____

Drug use? ☐ Yes ☐ No Type: _____ Quit date: _____

Caffeine per day: _____

Do you perform self breast exams? ☐ Yes ☐ No If so, how frequently? _____

How many days a week do you exercise: _____

Do you use a seat belt? ☐ Yes ☐ No

Do you have any objections to blood transfusions? ☐ Yes ☐ No

Do you have any history of sexual abuse? ☐ Yes ☐ No

Do you feel safe at home/work? ☐ Yes ☐ No