HEALTH HISTORY INFORMATION

Today's Date:

Name: Last, First, MI

Date of Birth:

What is the reason you're being seen today?

PAST SURGERIES

Please list any surgeries/operations you've had:

Type: ______________________ Date: ______________ Where: __________

Type: ______________________ Date: ______________ Where: __________

Type: ______________________ Date: ______________ Where: __________

Type: ______________________ Date: ______________ Where: __________

CURRENT MEDICATIONS

Please list any medications/vitamins you're currently taking:

Name: ______________________ Mgs/units: ______________ How often? __________

Name: ______________________ Mgs/units: ______________ How often? __________

Name: ______________________ Mgs/units: ______________ How often? __________

Name: ______________________ Mgs/units: ______________ How often? __________

MEDICATION ALLERGIES

Are you allergic to any medications? **If none write none here:** ______________

Name: ______________________ Type of reaction: ______________________

Name: ______________________ Type of reaction: ______________________

Name: ______________________ Type of reaction: ______________________

PAST MEDICAL HISTORY

Do you have any problems, diseases or disorders of the following?		
	No	Yes…… Please explain:
Anemia		
Bladder		
Bleeding/Clotting		
Blood Disorder		
Bowel		
Cancer		Type:
Depression		
Diabetes		
Fibromyalgia		

Headaches		
Hearing Problems		
Heart		
Hemorrhoids		
Hernia		
Kidney		
Liver/Hepatitis		
Mental Illness		
Neurological		
Osteoporosis		
Past Auto Accident		
Respiratory/Lung		
Seasonal Allergies		
Seizures		
STD's		
Skin		
Stomach/Intestines		
Thyroid		
Ulcers		
Vision		
OTHER:		

SOCIAL HISTORY: PLEASE CIRCLE

Marital Status	Single Married Divorced Separated Widowed Domestic Partner
Sexually Active	Yes No
Sexual Orientation	Heterosexual Homosexual Bisexual
Do you have a history of infertility?	Yes No
Education	Elementary High School Some College College Grad Post Grad
Occupation	
Stress Level	Low Moderate High
Exercise Level	None Occasional Moderate High
Diet	Regular Vegetarian Vegan Special:
Caffeine Intake	None Occasional Moderate Heavy
Smoking Status	Never Former Current How often? How long?
Alcohol Intake	None Occasional Moderate Heavy How long?
Illicit Drug Use	Never Former Current Type: How often?
Are there cats in your home?	Yes No
Do you work w/ chemicals or radiation?	Yes No

Have you had a LEEP or cone biopsy in the past?	Yes No If yes, when:
Do you routinely use seatbelts?	Yes No
Do you routinely use sunscreen?	Yes No
Is a blood transfusion acceptable in an emergency?	Yes No
Are you of Jewish ancestry?	Yes No
Are you of African American ancestry?	Yes No

FAMILY HISTORY:

Relationship	Problem	Onset Age	Died of Age
	___ Thyroid ___ Allergies ___ High Blood Pressure ___ Diabetes ____ Epilepsy ____ Stroke ___ Heart Disease ___ Mental Illness ___ Blood Disease ___ High Cholesterol ___ Other:		
	___ Thyroid ___ Allergies ___ High Blood Pressure ___ Diabetes ____ Epilepsy ____ Stroke ___ Heart Disease ___ Mental Illness ___ Blood Disease ___ High Cholesterol ___ Other:		
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GYN HISTORY:

Date of last period?	Approximate? Definite ?
How long does your period last?	
How many days between periods?	
How is the flow?	Light Moderate Heavy
Do you experience clotting?	
Are your periods painful?	Never Rare Occasionally Always
Age you began having periods?	
Do you have a history of abnormal paps?	
Were you treated for abnormal paps?	
Have you been treated for STD's?	
Are you currently sexually active?	
What are you using for birth control?	
Date of last mammogram	
Date of last pap smear	
Date of last bone mineral density screen	
Date of last cholesterol screen?	
Have you received the Gardasil injection?	
Age at first pregnancy?	

Planning future pregnancies?	
If menopausal, what age did it begin?	

OBSTETRIC HISTORY

Date of Delivery	Outcome? *(Full term, premature, miscarriage, termination)*	Length of Labor	Infant's weight	Infant's Sex	Delivery Type *(Vaginal, C/Section)*	Problems/Complications

Patient Signature: ____