

Name: _____	Date: _____
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WELCOME:

Your accurate completion of this health history is greatly appreciated. This will allow us to more accurately address your health problems and make recommendations. This information enables us to spend more quality time evaluating your present concerns and less time on the collection process of your previous health history. Please let us know if you have any questions and thank you for your assistance.

Age _____ Last Menstrual Period _____

Reason for today's visit: _____

Obstetrical History:

Total pregnancies: _____ Total Miscarriages: _____ Total Abortions: _____ Children Living: _____ Ectopic Preg.: _____

YEAR	SEX	WEIGHT	TYPE OF DELIVERY	COMPLICATION	LOCATION

Gynecologic History:

1. Menstrual History: Age at onset: _____ Length of time between periods: _____
How many days do you flow? _____ Do you have cramping? _____
When was your last period? _____
2. Age at first intercourse: _____
3. History of venereal disease such as warts, gonorrhea, Chlamydia, herpes, syphilis: _____
4. History of infection in uterus and/or fallopian tubes: _____
5. History of sexual abuse: _____ or physical abuse: _____
6. Date of last Pap smear: _____
History of abnormal Pap smear: _____ when? _____
7. History of heart disease: _____
8. Have you had a mammogram? _____ Date of last mammogram _____
9. Please check if you want a screening test for
Chlamydia/Gonorrhea _____ and/or AIDS _____

Personal Medical History

Surgical History – please list all surgery you have had and approximate dates:

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____

Trauma History – please list any broken bones, concussions, or injuries you may have had in the past:

- a. _____
- b. _____
- c. _____

Hospitalizations:

- a. _____
- b. _____
- c. _____

Please list any current medications you are taking: _____

Please list any allergies to medications: _____

Have you ever had any unusual childhood illnesses, such as rheumatic fever or seizures? _____

Past Medical History

Have you had any past history of medical problems in the following areas? If so, please describe.

- a. Eye or visual problems: _____
- b. Ear, nose or throat problems: _____
- c. Thyroid disorders or diabetes? _____
- d. Lung disease (such as Pneumonia, Bronchitis, Asthma): _____
- e. Heart problems or high blood pressure: _____
- f. Have you ever had a blood transfusion? _____
- g. Liver or Gallbladder disease (such as Hepatitis, Jaundice or Gallstones): _____
- h. Stomach disorders (such as Ulcers, Gastritis, Hiatal Hernia): _____
- i. Intestinal disorders (such as Colitis, Spastic Colon, Polyps): _____

j. Urinary Tract Infections: _____

k. Kidney Stones: _____

l. Anemia or blood clotting disorder: _____

m. Bone or Joint disease (such as Arthritis or Osteoporosis): _____

n. Neurological problems (such as Migraines): _____

o. Mental disorders (such as Depression, Anxiety Attacks, Nervous Breakdown): _____

Family History – please list any family members with the following illnesses (Parents, Grandparents, Aunts or Uncles):

a. Heart Disease: _____ Breast Cancer: _____ Osteoporosis: _____

b. High blood pressure: _____ Colon Cancer: _____ Thyroid Disorder: _____

c. Diabetes: _____ Ovarian Cancer: _____

d. Cancer: _____ Stroke: _____

e. Tuberculosis: _____ Kidney Disease: _____

Social History

a. Cigarette smoking: Yes / No Amount: _____

b. Frequency of alcohol use: _____

c. History of any drug use: _____

d. Occupation or type of employment: _____

Review of Systems – are you presently having any of these problems?:

- Chest pain, shortness of breath, irregular heart rate.
- Coughing up of sputum, blood or wheezing.
- Breast pain, nipple discharge or bleeding.
- Abdominal pain.
- Black, tarry stools, blood or mucus in stools.
- Persistent diarrhea or constipation.
- Pain or swelling in joints.
- Burning with urination, blood in urine, or unusual urinary frequency.
- Involuntary loss of urine.
- Vaginal discharge, burning or itching.
- Painful intercourse.
- Pelvic pain.

Questions:

Medical information may be shared with: _____
Name Relationship

Name Relationship Name Relationship