Health History

We are in the process of switching to electronic medical records. Please fill out this form completely, both sides, so we can better serve you and meet your healthcare needs.

Patient Name	**Date of Birth**	**Age**

Today's Date	**When was your last physical exam?**

Past Medical History - have you ever had the following

☐ **Patient Denies PMH**

		Date			Date			Date
☐	**Last Mammogram**		☐	Abnormal Pap		☐	Irritable Bowel	
☐	**Last Pap Smear**		☐	Arthritis		☐	Kidney Problems	
☐	**Last Bone Density**		☐	Asthma		☐	Migraines	
☐	**Last Cholesterol**		☐	Blood Clots		☐	Osteoporosis	
☐	**Last Colonoscopy**		☐	Blood Transfusions		☐	Seizure Disorder	
☐	**Last TB Skin Test**		☐	Cancer	**Type**			
☐	**Hepatitis A Vaccine**		☐	Depression		☐	STD	
☐	**Hepatitis B Vaccine**		☐	Diabetes		☐	Stomach Ulcers	
☐	**HPV Vaccines**		☐	Endometriosis		☐	Stroke	
☐	**Ifluenza Vaccine**		☐	Genital Herpes		☐	Thyroid Disease	
☐	**Pneumonia Vaccine**		☐	Heart disease		☐	Uterine fibroids	
☐	**Tetanus Shot**		☐	Hepatitis		☐	Genital Warts	
			☐	High Blood Pressure		Other disease(s)		

Past Surgical History - have you ever had the following

☐ **Patient Denies Surgery**

		Date(s)			Date			Date
☐	Appendectomy		☐	Cosmetic Surgery		☐	Hysterectomy	
☐	Bariatric Surgery		☐	D & C		☐	Knee/Hip Surgery	
☐	Breast Biopsy		☐	Endometrial Ablation		☐	Laparoscopy	
☐	Cesarean Section		☐	Exploratory Surgery		☐	Tubal Ligation	
			☐	Gallbladder Surgery		Other Surgery		

Medication – Please list all medicines you are currently taking including vitamins, herbals or over-the-counter meds

☐ **Patient Denies taking Medication**

Medication	Dosage	How often per day

Allergies – Please list all allergies to medication, food and environment

☐ **Patient Denies Allergies**

Allergy	Reaction

Family Medical History - have your parents, grandparents or brothers/sisters ever had the following					**Patient Denies Family Hx of** ☐ Breast Cancer ☐ Colon Cancer ☐ GYN Cancer
		Relationship			**Relationship**
☐	Blood Clots		☐	Kidney Problems	
☐	Cancer	**Type**			
☐	Diabetes		☐	Osteoporosis	
☐	Genetic Problem		☐	Seizure Disorder	
☐	Heart Disease		☐	Stroke	
☐	High Blood Pressure		☐	Other Diseases	

Menstrual History

Age of First Period #	
Days Between Periods #	
Flow ☐ Light ☐ Medium ☐ Heavy	Clotting with Periods ☐ Yes ☐ No
Total days on Period #	
Date of Last Period	
Method of Birth Control	
Menopause Status	Age of Menopause
Bleeding in Between Periods ☐ Yes ☐ No	Hormone Replacement Therapy ☐ Yes ☐ No

Pregnancies

Total # Pregnancies					
Full-term deliveries #		Premature deliveries #		Terminated #	
Miscarriages #		Ectopic #		Multiple #	
Total # Living Children					

Pregnancy Details

Date of Delivery	Birth Wgt	Sex	Type of Delivery	Complications	Location

Social History

Marital Status	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	
Occupation		
Do you smoke? ☐ Yes ☐ No	If yes, type and amount per day?	
Did you smoke in the past? ☐ Yes ☐ No	If yes, when did you quit?	
Do you drink alcohol? ☐ Yes ☐ No	If yes, type and amount per week?	
Do you use Street drugs? ☐ Yes ☐ No	If yes, type and amount per day?	

Patient Signature	**Date**