Health History Form

Date:_________

Patient Name:__________________________________ **DOB:____________** **Age:______**

Marital status: □ Single □ Married □ Domestic Partner □ Widowed □ Divorced □ Remarried

Occupation:_________________________ **Social Security Number:_______________________**

Address:_____________________________ **City:_________________** **State:____** **Zip:________**

Phone: Home:______________ **Work:______________** **Cell:________________**

Emergency Contact Name:_____________________ **Relationship to Patient:_____________**
Phone: Home:______________ **Work:______________** **Cell:________________**

Ethnicity: ( ) Decline to answer ( ) Hispanic/Latina ( ) Non- Hispanic/Latina ( ) Unknown

Race: ( ) American Indian/Alaskan Native ( ) Asian ( ) Black/African American ( ) Caucasian ( ) Decline to answer
( ) Native Hawaiian/Pacific Islander ( ) Other:__________________________ ( ) Unknown

E-mail:____________________ **Preferred method of communication:** □ Phone □ Mail □ E-mail □Text

Primary Physician:_______________________ **Phone:_________________** **Fax:______________**

Pharmacy:______________________________ **Phone:_________________** **Fax:_______________**

Reason for your visit today: □ Annual Gyn Exam □ First Obstetrical Visit □ Gyn Problem Visit

Please describe your concerns:____

THANK YOU IN ADVANCE FOR COMPLETING THIS LENGTHY FORM. IT WILL MAKE YOUR VISIT AS EFFICIENT AS POSSIBLE, AND HELP US TO GIVE YOU THE BEST POSSIBLE CARE.

Health Maintenance Screening Tests:

Most Recent Testing:

Mammogram	□Yes □No	If yes, date ___/___/___	Results:	□Normal	□Abnormal
U/S of Pelvis	□Yes □No	If yes, date ___/___/___	Results:	□Normal	□Abnormal
Genetic Screening BRCA 1 BRCA 2	□Yes □No	If yes, date ___/___/___	Results:	□Normal □Normal	□Abnormal □Abnormal
Colonoscopy	□Yes □No	If yes, date ___/___/___ Next test due ___/___/___	Results:	□Normal	□Abnormal
DEXA Bone Density Scan	□Yes □No	If yes, date ___/___/___	Results:	□Normal	□Abnormal

Pap Smear History:

Pap smear	□Yes □No	If yes, date ___/___/___	Results:	□Normal	□Abnormal
Colposcopy	□Yes □No	If yes, date ___/___/___	Results:	□Normal	□Abnormal
LEEP	□Yes □No	If yes, date ___/___/___	Results:	□Normal	□Abnormal
History of HPV?	□Yes □No	If yes, date ___/___/___			
HPV vaccine?	□Yes □No	If yes, dates of injection	#1___/___/___	#2___/___/___	#3___/___/___

Other Immunizations/Vaccines (not the illness itself)

Chicken Pox	□Yes □No	If yes, year________	Shingles	□Yes □No	If yes, year__________
Flu	□Yes □No	If yes, year________	TDAP	□Yes □No	If yes, year__________
Hepatitis B	□Yes □No	If yes, year________	Tetanus	□Yes □No	If yes, year__________
Other		Year _________			

Patient Medical History: Please check if you have now or have ever had in the past ☐ None

	Yes			Yes
Anemia			Hypertension	
Anxiety			Hyperthyroid	
Arthritis/Joint Pain			Hypothyroid	
Asthma/Breathing Problems			IBS (Irritable Bowel Syndrome)	
Bipolar			Interstitial Cystitis	
Blood Clot: leg or lung			Kidney Infections (Pyelonephritis)	
Blood Transfusions			Kidney Stones (Renal Calculi)	
Cancer (type):			Lupus or other Autoimmune disease	
Chest Pain			Migraines: ☐with Aura ☐ without Aura	
Chronic Lung Disease			Osteopenia	
Depression			Osteoporosis	
Diabetes Type 1			Recurrent Urinary Tract Infections (UTI's)	
Diabetes Type 2 (adult onset)			Reflux (GERD)	
Diverticulosis/itis			Schizophrenia	
Eating Disorder			Seizure Disorder	
Glaucoma			Stroke (CVA)/Transient Ischemic Attacks (TIA)	
Heart Arrhythmia			Tuberculosis (TB) or exposure to TB	
Heart Attack/Failure			Ulcers	
Hepatitis ☐A ☐B ☐C			Other	
High Cholesterol				

Reproductive Health History:

Abnormal Menstrual Bleeding		Hormone Therapy in the past		Polycystic Ovaries	
Abnormal Pap		Infertility		Uterine Polyps	
Endometriosis		Pelvic Pain		Vaginal Infections, Recurrent	
Fibroids		Pelvic Relaxation/Prolapse		Other	

Past Surgical History: ☐ None Have you ever had any complications from anesthesia? ☐No ☐Yes

Year	Surgery	Hospital/Surgeon if known

Current Medications: ☐ None If there is not sufficient space please attach copy of medications list to this form.

Please include prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs:

Medication	Dosage (include unit)	Frequency	Prescribing Physician

Name:__________________________________

Allergies: (Food, Drugs, Environmental): ☐None Latex ☐ No ☐ Yes Iodine ☐ No ☐ Yes

Allergy	Reaction	Allergy	Reaction

Family Medical History: ☐ Family History unknown

Please check the appropriate column and note the AGE at diagnosis if known, and the TYPE of cancer if not listed:

	Mother	Father	Brother	Sister	Grand Mother (Maternal)	Grand Mother (Paternal)	Grand Father (Maternal)	Grand Father (Paternal)	Aunt	Uncle
Blood Clots/DVT/PE										
Breast Cancer										
Cervical Cancer										
Colon Cancer										
Diabetes										
Heart Disease										
Mental Illness										
Osteoporosis										
Ovarian Cancer										
Stroke										
Thyroid Disease										
Uterine Cancer										
Cancers not mentioned										
*Benign GYN problems										

*Such as early/late menopause, endometriosis, fibroids, infertility

Reproductive History:

Gynecology:

Age at first menstrual period:	Frequency of period: every __________ days
Length/duration of period: _____ days	Describe Period Flow: ☐Light ☐Medium ☐Heavy
Number of tampons used per day of period _____	Number of pads used per day of period _____
Date of the 1st day of your last period:	Current contraceptive method:
Are you post-menopausal? ☐Yes ☐No	If yes, how old were you when you had your last period:
	Are you on hormone replacement therapy? ☐Yes ☐No

Name:________________________________

Obstetrics:

Total # of:
Pregnancies_____

Full Term Births _____ Preterm Births _____ Ectopic Pregnancies _____ Induced Abortions _____ Mis-carriages _____ Living Children _____

#	Birth Date	#wks at del	Hrs in Labor	Birth Weight	Gender	Type: Vaginal or C-section	Epi-dural?	Complications/reason for C-section*	Location of del**
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									

***preterm labor, diabetes, hypertension, breech, decreased amniotic fluid, growth restriction, etc.**

****hospital name or state**

Genetic History: ☐ **Unknown** **Include yourself, your partner, and everyone on both sides of the family. This is particularly important if you are pregnant or are planning pregnancy in the near future.**

	Yes	No		Yes	No
Autism			Metabolic Disorder		
Congenital Heart Defect			Muscular Dystrophy		
Cystic Fibrosis			Neural Tube Defect (Spina Bifida/Anencephaly)		
Down Syndrome					
Dyslexia			Recurrent pregnancy loss or a still birth		
Fragile X			Sickle Cell Trait or Disease		
Hemophilia			Spinal Muscular Atrophy (SMA)		
Huntington's Chorea			Tay-Sachs		
Learning Disabilities other than Dyslexia			Thalassemia		
Mental Retardation, cause unknown			Other genetic/chromosomal problems or birth defects		

Is your family Greek/Mediterranean? ☐ Yes ☐ No Is your partner's family? ☐ Yes ☐ No
Is your family Jewish/Cajun/French Canadian? ☐ Yes ☐ No Is your partner's family? ☐ Yes ☐ No

SKIP THESE QUESTIONS IF YOU ARE NOT CURRENTLY PREGNANT OR PLANNING PREGNANCY

Are you a vegetarian? ☐ Yes ☐ No
Are there any hazards or exposures at home or work? ☐ Yes ☐ No
Do your home or work activities require heavy lifting or other strenuous activity? ☐ Yes ☐ No
Have you had any X-rays, rashes, infections, medications, drugs or alcohol since your last period? ☐ Yes ☐ No
Are you interested in genetic counseling and/or testing? ☐ Yes ☐ No

Name:________________________________

Additional Gyn History:

Check if you have ever used: ☐ birth control pill/vaginal ring/patch (please circle) ☐ intrauterine device (IUD)
☐ injectable birth control (Depo-provera) ☐ diaphragm ☐ implantable rod(s)
Do you perform breast self exams? ☐ Yes ☐ No

Have you ever had a breast biopsy? ☐ Yes ☐ No

Did your mother take DES when she was pregnant with you (to your knowledge)? ☐ Yes ☐ No

Have you ever had vaginal intercourse/sex? ☐ Yes ☐ No If no, please go to the next section (Substance Use).

Current sexual partner(s) is/are: ☐ Male ☐ Female ☐ Male and Female ☐ Not currently active
Were you under the age of 18 when you first had sex? ☐ Yes ☐ No
How many sexual partners have you had? ☐1-5 ☐ 6-10 ☐ 11-20 ☐ over 20
Check if you have ever had any of the following STIs:
☐ Chlamydia ☐Cold Sores ☐Genital Herpes ☐Gonorrhea ☐Hepatitis B ☐Hepatitis C ☐Syphilis
Check if your current or past partner(s) has/have ever had any of the following STIs:
☐ Chlamydia ☐Cold Sores ☐Genital Herpes ☐Gonorrhea ☐Hepatitis B ☐Hepatitis C ☐Syphilis
Are you interested in testing/screening for STIs? ☐ Yes ☐ No
Have you ever been sexually assaulted? ☐ Yes ☐ No

Substance Use:

Do you currently use tobacco products? ☐ Yes ☐ No
If no, have you been a smoker in the past? ☐ Yes ☐ No
If yes, how many cigarettes a day? _______
Age you started smoking: _____ Age you quit smoking: _____

Do you drink alcohol? ☐Yes ☐ No If yes, how many drinks per week? _______

Do you use recreational/street drugs? ☐ Yes ☐ No If yes, what kind? ______________________________

Safety/Life Style:

Have you ever been involved in domestic violence? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No
With whom do you share your home? ____

Do you drink milk and/or consume dairy products daily? ☐ Yes ☐ No
Do you take calcium supplements? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No If yes, how many times a week? ______
Are you satisfied with your weight? ☐ Yes ☐ No

AUTHORIZATION AND RELEASE:
I hereby certify that I have completed the above information to the best of my knowledge. I agree to actively participate in routine assessments, and in making decisions regarding the performance of diagnostic tests and procedures, and treatment as recommended by my physician, and/or her assistants or designees.

____
Name

____ ______________________________
Signature **Date**

PLEASE fax or mail your completed form to our office prior to your appointment. If you cannot return your form prior to your appointment, PLEASE arrive 30 minutes early so we can enter your information into the computer. **THANK YOU.**

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