HEALTH HISTORY FORM

It is important that this information is updated yearly, to provide you with the best care possible

Name ____ Date of birth ____________

Today's Date ______________ Reason for visit ________________________________

GYNECOLOGICAL HISTORY

Date of last menstrual period ____________ Are your cycles monthly? ____________

Date of last pap smear _________________ RESULT ABNORMAL or NORMAL (CIRCLE ONE)

Date of last mammogram _______________ RESULT ABNORMAL or NORMAL (CIRCLE ONE)

How are you preventing pregnancy? (Circle one) I'm Not Abstinence Birth Control Pills

Condoms Depo Provera IUD Menopause Hysterectomy No Heterosexual Sex

Vasectomy Tubal Ligation Natural Other _____________________

Please check any that apply.

☐ Abnormal Pap Smear ☐ Abnormal Periods ☐ Abnormal Mammogram ☐ Endometriosis

☐ Menopause ☐ Pelvic Pain ☐ Infertility ☐ STD's ☐ Fibroids ☐ Other _______________

PERSONAL MEDICAL HISTORY *Please check any that apply.*

☐ Asthma
☐ Blood Clots (DVT)
☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Migraines
☐ Pulmonary Embolism
☐ Psychiatric Disorder
☐ Thyroid Disease
☐ Seizure/Epilepsy
☐ OTHER ____

ALLERGIES

Do you have any drug allergies? ☐ YES ☐ NO

Are you allergic to latex? ☐ YES ☐ NO

Please list allergies (medications, latex, etc.) Reaction (hives, rash, etc.)

____

____

____

SOCIAL HISTORY

Marital Status ________________________ Are you sexually active? ______________

New partner? ☐ YES ☐ NO If not currently active, have you been before? ☐ YES ☐ NO

How often do you drink? ☐ Socially ☐ Daily ☐ Never

Do you smoke? ______ If so, how many packs per day? _______ If you quit, when? ________

Do you or have you ever used street drugs? _________ If so, which drugs? ______________

How often do you exercise? ☐ Daily ☐ Some days ☐ Most days ☐ Never

Caffeine use ☐ Daily ☐ Sometimes ☐ Never

Seatbelt use ☐ Always ☐ Sometimes ☐ Never

OBSTETRICAL HISTORY

# of Pregnancies ________ # of Miscarriages ________ # of Abortions ________

# of Pre-Term Births ________ # of Living Children ________

Current Medications, Including Birth Control (Please write “none” if you are not taking any medications)

DRUG NAME DOSAGE

____

____

____

Surgical History *Please list any surgeries you have had.*

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Family History *Please list check any illnesses your immediate family has AND write the relation to you.*

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anxiety
- ☐ Asthma
- ☐ Autoimmune
- ☐ Blood Clots (DVT)
- ☐ Breast Cancer
- ☐ Cervical Cancer
- ☐ Cholesterol
- ☐ Colon Cancer
- ☐ Colon Polyp
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Melanoma
- ☐ Migraine
- ☐ Osteoporosis
- ☐ Prostate Cancer
- ☐ Stroke
- ☐ Seizure/Epilepsy
- ☐ Cancer ____________________________
- ☐ OTHER ____