



# Patient Health History Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

**Medical History:** Have you ever had any of the following?

<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Clots in Lungs/Legs	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Heart Disease/Heart Attack	<input type="checkbox"/> Gall Bladder Disease
<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Liver Disease/Hepatitis	<input type="checkbox"/> Migraines	<input type="checkbox"/> Sickle Cell Disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Depression/Anxiety
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Bladder Infections
<input type="checkbox"/> Drug or Alcohol Problem	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Pelvic Infections	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Genetic Condition(s)
<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Cancer	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Other (please list below)

Other major medical issues: \_\_\_\_\_

**Surgical History:** Please list any/all surgeries you've had with the approximate date of surgery:

\_\_\_\_\_

\_\_\_\_\_

**Obstetrical History:**

Please list pregnancies in order, including miscarriages, premature births, stillbirths, ectopic (tubal) pregnancies, and abortions:

Year	M/F	Weight	Type of Delivery	Length of Pregnancy	Problems (pre-term labor, diabetes, high blood pressure, etc.)	Name/Age

- Check here if you have **never** been pregnant
- Check here if you have adopted children. If so, please list names/ages: \_\_\_\_\_

**Gyn History:**

Age of first period: \_\_\_\_\_      Period are: \_\_\_ Regular      Flow is: \_\_\_ Light  
 Age of last period: \_\_\_\_\_      \_\_\_ Irregular      \_\_\_ Light to Moderate  
 Cycle Length: every \_\_\_\_\_ days      \_\_\_ Painful      \_\_\_ Moderate to Heavy  
 Cycle lasts \_\_\_\_\_ days      \_\_\_ Not bothersome      \_\_\_ Very Heavy

Are you sexually active? Yes \_\_\_ No \_\_\_ If yes, please list the number of sexual partners in your lifetime: \_\_\_\_\_

Method of Birth Control Used: \_\_\_\_\_

Have you ever had any of the following STDs? Check all that apply:

<input type="checkbox"/> Chlamydia	<input type="checkbox"/> HPV	<input type="checkbox"/> HIV
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Trichomonas	<input type="checkbox"/> Hepatitis C

Do you have or have you ever had any of the following conditions? Check all that apply:

<input type="checkbox"/> Fibrocystic Breasts	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Ovarian Cysts	<input type="checkbox"/> Uterine Fibroids

Date of last Pap smear: \_\_\_\_\_ Result of last Pap smear (normal or abnormal): \_\_\_\_\_

Have you ever needed or has it been medically recommended that you have any of the following procedures done due to an abnormal Pap result? Check all that apply:

<input type="checkbox"/> Colposcopy	<input type="checkbox"/> LEEP/Laser/Conization
<input type="checkbox"/> Cryosurgery	<input type="checkbox"/> Hysteroscopy
<input type="checkbox"/> Other: Please List: _____	

Date and result of last mammogram: \_\_\_\_\_

Date and result of last bone density: \_\_\_\_\_

Date and result of colonoscopy: \_\_\_\_\_

**Family History:** Please list any close relatives with a history of any of the following:

Condition	Relative and Age of Diagnosis
<input type="checkbox"/> Breast Cancer	
<input type="checkbox"/> Ovarian Cancer	
<input type="checkbox"/> Uterine Cancer	
<input type="checkbox"/> Colon Cancer	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Heart Disease (including heart attack, stroke, bypass surgery)	

**Social History:** Please circle yes or no and if yes, answer the questions appropriately:

Alcohol Use	Yes	No	Number of drinks per day/week/month:	
Tobacco Use	Yes	No	Number of pack(s) per day and number of years:	
Street Drug Use	Yes	No	Type and frequency:	
Exercise	Yes	No	Type and frequency:	
Caffeine	Yes	No	Number of caffeinated drinks per day/week:	
Sexual Abuse	Yes	No	Are you safe now?	Have you received counseling?
Physical Abuse	Yes	No	Are you safe now?	Have you received counseling?
Emotional Abuse	Yes	No	Are you safe now?	Have you received counseling?

**Review of Systems:** Do you currently have any of the following conditions and/or symptoms?

<input type="checkbox"/> Recent weight gain or loss of 25 or more lbs.	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/> Fever	<input type="checkbox"/> Burning with Urination
<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Urgency
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Bladder Infection
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Pelvic Pain
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Painful Sexual Intercourse
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Breast lumps
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Joint/Muscle Pain
<input type="checkbox"/> Constipation	<input type="checkbox"/> Depression/Anxiety
<input type="checkbox"/> Blood in Stools	<input type="checkbox"/> Heartburn/Reflux

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Annual Review Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2<sup>nd</sup> Annual Review/Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

3<sup>rd</sup> Annual Review/Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\* If it has been over three years since completing this form, you may be asked to complete a new Health History Form.