

HEALTH HISTORY

PATIENT NAME _____ DOB ____ / ____ / ____ AGE _____

PHARMACY AND PHARMACY NUMBER _____

How did you hear about our office? _____

To help us meet all your healthcare needs, please fill out this form completely. This is a confidential record of your medical history and will be kept in this office.

Today's date _____ When was your last physical exam? _____

1. MEDICATIONS:

Please list all medicines you are currently taking

CURRENT MEDICATIONS:	DOSAGE (mg)	how often per day?	INDICATIONS/REASON:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Please list all ALLERGIES and reaction:

_____ No Known Drug Allergies

3. PAST MEDICAL HISTORY – Have you ever had the following: (Circle “no” or “yes”, leave blank if uncertain)

Abnormal pap test	no	yes	Sickle cell trait	no	yes
Prior cervical procedures	no	yes	Thrombophilia (bleeding)	no	yes
Sexually transmitted infections	no	yes	Coagulopathy (clotting)	no	yes
Fibroids	no	yes	Cancer	no	yes Type: _____
Endometriosis	no	yes	Depression	no	yes
Breast biopsy	no	yes	Anxiety	no	yes
Abnormal mammogram	no	yes	ADD/ADHD	no	yes
Hypertension	no	yes	Asthma	no	yes
Hypercholesterolemia	no	yes	Skin disorders	no	yes
Heart Disease	no	yes	Incontinence	no	yes
Stroke	no	yes	Kidney stones	no	yes
GERD (Reflux)	no	yes	Kidney infections	no	yes
Thyroid disorder	no	yes	Recurrent bladder infection	no	yes
Diabetes	no	yes	Any other disease	no	yes
Anemia	no	yes			

Please explain any “yes” answers or list any other pertinent medical history:

4. PAST SURGICAL HISTORY –

Please list all serious illnesses, operations & other hospitalizations you have experienced and indicate the year these occurred:

	Type	Date/Reason
Surgeries	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

5. MENSTRUAL HISTORY:

Age at first period _____
 Cycle interval _____
 Duration of menses _____
 Last menstrual period _____
 Method of birth control _____
 Menopause Yes/No _____ Age at menopause _____
 Breakthrough bleeding Yes/No _____ Are you on hormone replacement therapy Yes/No _____

6. PREGNANCY:

Total pregnancy # _____
 Full term # _____ Premature # _____ Voluntary terminations # _____ Miscarriages # _____ Ectopics # _____ Multiples # _____ Living # _____

Pregnancy Details:

Date:	Weeks:	Birth Weight:	Boy/Girl:	Type of Delivery:	Complications:	Name of Child and Location of Delivery:

7. SOCIAL HISTORY:

Smoking (amount) _____ If former smoker, date quit _____
 Alcohol (type & amount per week) _____
 Street drugs (type & amount per day) _____
 Caffeine (type & amount per day) _____

Occupation: _____

Exercise (type and amount): _____

Relationship Status: Dating Divorced Engaged Married Same Sex Couple Single Widowed

8. FAMILY HISTORY: Has any blood relative had any of the following: (Circle “no” or “yes”, leave blank if uncertain)

			<u>Relationship</u>	<u>Age at Diagnosis</u>	
Blood Clots	no	yes	_____	_____	
Breast Cancer	no	yes	_____	_____	
Colon Cancer	no	yes	_____	_____	
Ovarian Cancer	no	yes	_____	_____	
Other Cancers	no	yes	_____	_____	Type _____
Diabetes	no	yes	_____	_____	
Heart Disease	no	yes	_____	_____	
High Blood Pressure	no	yes	_____	_____	
Stroke	no	yes	_____	_____	

9. REVIEW OF SYSTEMS:

Do you have or have you had any of the below problems within the past year: (Circle any problems you have had)

Constitutional:	fever	weight change	fatigue	
Eyes:	blurred vision	double vision		
ENT:	sinus problems	headaches	dental problems	
Breast:	pain in breast	lumps/masses	nipple discharge	
Cardiovascular:	chest pain	irregular heartbeats	swelling of legs	
Respiratory:	asthma	shortness of breath		
Gastrointestinal:	bloating	constipation/diarrhea	nausea/vomiting	blood in stool
Genitourinary:	urgency	frequency	pain with voiding	incontinence
Integument:	rash	itching		
Neurologic:	seizure	numbness	dizziness	
Musculoskeletal:	back pain	joint pain	muscle pain	
Endocrine:	hot flashes	night sweats	cold/heat intolerance	
Psychiatric:	anxiety	depression	memory loss	confusion
Heme-Lymph:	easy bleeding	easy bruising	anemia	blood transfusions
Allergic- Immunologic:	allergies	hepatitis	frequent illnesses	

Signature of Patient or parent if minor

12/11

Date