

Confidential Health History



Name: _____
Date of Birth: _____
Pref. Pronouns: She/Her, He/Him, They/Them, Other: _____
Primary Care Physician: _____

Past Medical History – Circle All That Apply:		Past Surgical History – Please note approximate year for applicable surgeries:	
Abnormal Pap Smear/HPV Asthma Autoimmune Disease Cancer (type): _____ Depression or Anxiety Diabetes Endometriosis Fibroids Heart Disease High Blood Pressure	Incontinence Infertility Migraines Sexually Transmitted Infections: _____ Thyroid Disorder Other: _____ _____ _____	Appendectomy Bladder Repair Cesarean Section Dilation + Curettage (D&C) Hysterectomy Hysteroscopy Laparoscopy Ovaries Removed Tubal Sterilization Vaginal Wall Repair Other: _____ _____	Year _____ Year _____

List any other health problems: _____

Family History	Social History
Please indicate any 1 st degree relatives (parents, siblings) who have any of the following: Cancer (type) _____ Diabetes _____ Heart Disease _____ High Blood Pressure _____ Inheritable Anemia _____ Blood Disorders _____ Kidney Disease _____ Lung Disease _____ Throid Disease _____ Other: _____ _____ _____	As health care providers, we realize many people live in less than ideal situations, and it is our responsibility to offer help if you are in an unsafe environment. Please let us know if you do not feel safe in your current relationship or would like a referral to a mental health or legal professional. Please circle yes or no: <ul style="list-style-type: none"> Do you feel safe in your relationship? Yes/No Are you being hurt in any way? Yes/No Have you ever been forced to have sex against your will? Yes/No Do you have anything you want to tell us that might influence your care? Yes/No _____ _____

Medications	Drug Allergies and Reaction
Please list medications (including herbals) and dosage you are currently taking: _____ _____ _____ _____	Please list any drug allergies and reactions (e.g., sulfa = rash): _____ _____ _____ _____

GYN History

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| <ul style="list-style-type: none"> • Date of last menstrual period ____/____/____ • Number of days your flow lasts _____ • Average number of days from the beginning of one cycle to the beginning of next cycle _____ • Any bleeding between cycles? Yes/No | <ul style="list-style-type: none"> • Are you currently sexually active? Yes/No • Any bleeding after intercourse? Yes/No • Birth control method: _____ • Planning a pregnancy in the next year? Yes/No |
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Reproductive History

Number of pregnancies _____		Number of live births _____		Number of Miscarriages/Abortions _____	
Birth Month/Year	Sex	Birth Weight	Term or Preterm	Type of Delivery (Vaginal or C-Section)	

Preventative Health Behaviors

<p>Do you (circle yes or no):</p> <ul style="list-style-type: none"> • Smoke? Yes/No • Drink alcohol? Yes/No • Use recreational drugs? Yes/No • Exercise regularly? Yes/No 	<p>When was your most recent:</p> <ul style="list-style-type: none"> • Mammogram? Year _____ • Colonoscopy? Year _____ • Cholesterol screening? Year _____ • Bone mineral density (DEXA)? Year _____ 	
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Patient Signature: _____ **Date:** _____