Confidential Health History

Name ______________________________

Date of Birth ______________ Age ____

Social Security Number _______________

Primary Physician ____________________

Please list medications ***(including herbals)*** and dosage you are currently taking:	Please list drug allergies and reaction (e.g. sulfa = rash):
______________________________ ______________________________ ______________________________ ______________________________ ______________________________	______________________________ ______________________________ ______________________________ ______________________________ ______________________________

Past Medical History - Circle All That Apply:		**Past Surgical History** - Please note approximate year for applicable surgeries:	
Abnormal Uterine Bleeding	Anemia	Hysterectomy	Year ______
Abnormal PAP Smear	Arrhythmia	Laparoscopy	Year ______
Fibroids	Heart Disease	Hysteroscopy	Year ______
Herpes / Other STD	High Blood Pressure	Bladder Repair	Year ______
Infertility	High Cholesterol	Appendectomy	Year ______
HIV or AIDS	Asthma	Cesarean Section	Year ______
Breast Disease/Lumps	Tuberculosis	Ovaries Removed	Year ______
GERD / Hiatal hernia	Bladder Infection	Tubal Banding? Ligation	Year ______
Irritable Bowel Disease	Incontinence	Cervical Cone Biopsy	Year ______
Colitis or Inflammatory	Kidney Disease or Stone	Vaginal Wall Repair	Year ______
Bowel Disease	Anxiety Disorder	Gallbladder Removal	Year ______
Hepatitis	Migraine Headaches	Tonsillectomy/Adenoidectomy	Year ______
Stomach Ulcers	Depression		
Diabetes	Cancer (type) __________	Other:	
Thyroid Disorder	Other _______________	_________________	Year ______
		_________________	Year ______

List any other health problems:

____

____

____

Reproductive History

- ✓ Age at first menstrual period ______
- ✓ Average number of days from the **beginning** of one cycle to the **beginning** of next cycle ______
- ✓ Number of pregnancies ______
- ✓ Number of live births ______
- ✓ Number of miscarriages /abortions ____ /____

- ✓ Date of last menstrual period _____ /_____ /_____
- ✓ Number of days your flow lasts ______
- ✓ Any bleeding between cycles? Yes / No
- ✓ Are you currently sexually active? Yes / No
- ✓ Any bleeding after intercourse? Yes / No
- ✓ Birth control method: ______________________
- ✓ Satisfied with current method? Yes / No
- ✓ Planning a pregnancy in the next year? Yes / No

Reproductive History - continued				
Birth Mo/ Year	**Sex**	**Birth Weight**	**Term or Preterm**	**Type of Delivery (Vaginal or C/S)**

Family History	Social History
Please indicate any ***immediate*** family members who have any of the following: Diabetes ___________________________ Heart Disease ___________________________ High Blood Pressure ___________________________ Kidney Disease ___________________________ Thyroid Disease ___________________________ Cancer (type) ___________________________ Lung Disease ___________________________ Inheritable Anemia / Blood Disorders ___________________________ Depression/Mental Illness/Alzheimer's ___________________________ 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. ✓ 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 ___________________________

Preventive Health Behaviors	Yes	No
Do you?		
Smoke (if yes, how many / day _______)	______	______
Drink alcohol (if yes, how many / week _______)	______	______
Use recreational drugs	______	______
Perform self-breast exams monthly	______	______
Use sunscreen daily	______	______
Have eye exams annually	______	______
See a dentist every 6-12 months	______	______
Use seatbelts consistently	______	______
Exercise regularly	______	______

	Yes	No	N/A	Don't Know
Vaccines current?				
Tetanus Year of last one ______	______	______	______	______
Diphtheria Year of last one ______	______	______	______	______
Hepatitis Year of last one ______	______	______	______	______
Flu Year of last one ______	______	______	______	______
Ever had?	______	______	______	______
a mammogram Year of last one ______	______	______	______	______
a colonoscopy Year of last one ______	______	______	______	______
a cholesterol screening Year of last one ______				
a bone mineral density Year of last one ______				

Patient Signature: ______________________________________ *Date:* _____________