

Patient History

Name: _____

DOB: ____ - ____ - ____

Physician @ Seattle OB/GYN: _____

Primary Care Physician: _____ I do not have a primary physician.

Referred by: _____ Pharmacy Location: _____

VITALS: systolic #__ diastolic #__ position: _____ Pharmacy Phone: (____) _____

Heart rate # beats per minute _____ Regular _____ Irregular _____ Weight _____ Height _____

PAST MEDICAL HISTORY: (Check if you have ever had or been diagnosed with any of the following)

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fibrocystic Breast Disease | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> Premenstrual Syndrome |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Bowel Troubles | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cervical Dysplasia | <input type="checkbox"/> Herpes, Genital | <input type="checkbox"/> Transfusions |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Trichomonas |
| <input type="checkbox"/> Chronic Lung Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Deep Venous Thrombosis | <input type="checkbox"/> Infertility | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Yellow jaundice or hepatitis |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Kidney Stones | |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Mental Illness | |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Other _____ | | |

HEALTH SCREENINGS

- Last Bone Density Test** Year: _____ Normal Abnormal _____
- Last Cholesterol Level** Year: _____ Normal Abnormal _____
- Last Colonoscopy** Year: _____ Normal Abnormal _____
- Last Diabetes Test** Year: _____ Normal Abnormal _____
- Last Mammogram:** Year: _____ Normal Abnormal _____
 Previous abnormal mammograms? No Yes, Year _____ Treatment: _____
- Last Pap smear:** Year: _____ Normal Abnormal _____
 Previous abnormal Pap smears? No Yes, Year _____ Treatment: _____
- Last Thyroid Test** Year: _____ Normal Abnormal _____
- Gardasil** Did you get all 3 shots of the HPV vaccine? _____ Which Year? _____

PAST SURGICAL HISTORY: (Please check any that you have had)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Appendectomy _____ | <input type="checkbox"/> D&C _____ | <input type="checkbox"/> Hysterectomy _____ | <input type="checkbox"/> Tubal Ligation _____ |
| <input type="checkbox"/> Breast _____ | <input type="checkbox"/> Gallbladder _____ | <input type="checkbox"/> Ovary _____ | <input type="checkbox"/> Vaginal Repair _____ |
| <input type="checkbox"/> Cesarean section _____ | <input type="checkbox"/> Heart _____ | <input type="checkbox"/> Tonsillectomy _____ | |
| <input type="checkbox"/> Other _____ | | | |
| <input type="checkbox"/> Other _____ | | | |

CURRENT MEDICATIONS: (List all medications, even over the counter, vitamins, herbal remedies, etc. Include the following information regarding your medications. You may use additional pages if necessary. Also, please bring all your medications with you to your appointment.)

Medication	Strength	How Often	Prescribed By	Reason

ALLERGIES

Medication Allergies: _____ Food Allergies: _____ Environmental _____

REACTIONS:

FAMILY HISTORY: (Please check if any of your family members have had the following)

	Mother	Father	Brother	Sister	Mom's Mother	Dad's Mother	Mom's Father	Dad's Father	Aunt	Uncle
Breast Cancer										
Colon Cancer										
Diabetes										
Heart Disease/ MI										
High Blood Pressure										
Ovarian Cancer										
Uterine Cancer										
Stroke										
Other Cancer not mentioned:										
Other:										

GYNECOLOGICAL HISTORY: (Fill in blanks or check boxes where appropriate)

Age at first menstrual period: ____ years Days between the first day of each period: ____ days Length of each period: ____ days

Flow: Light Medium Heavy # of Tampons used per day ____ # of Pads used per day ____

Last normal menstrual period: ____/____/____

Menopausal Status: Premenopausal Perimenopausal Postmenopausal Age at Menopause ____

Do you use contraception? Yes No (If yes, please check type)

- | | | | |
|--|---------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Birth Control Pills | <input type="checkbox"/> Depo Provera | <input type="checkbox"/> Foam | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> NuvaRing | <input type="checkbox"/> IUD | <input type="checkbox"/> Condoms | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Ortho Evra | <input type="checkbox"/> Diaphragm | | <input type="checkbox"/> Other _____ |

Breakthrough bleeding: Yes No Clots: Yes No

OBSTETRICAL HISTORY:

Pregnancies ____ Full-Term ____ Pre-term ____ Abortions ____ Miscarriages ____ Tubal Pregnancies ____ Multiple ____ Living ____

Date	Weeks	Labor Hrs	Weight	Sex	Delivery Type	Anesthesia	Early Labor?	Complications	Location/Physician

SOCIAL HISTORY:

Marital Status: Single Engaged Married Divorced Separated Widowed Dating Not Dating

Are you sexually active? Yes No

Education: Grade completed ____ Graduated High School GED Some College
 Graduated College – 2 YR Graduated College – 4 YR Postgraduate

Tobacco Use Never Current Former Amount _____ Started _____ Stopped _____

Alcohol Use Never Current Former Amount _____ Started _____ Stopped _____

Recreation Drug Use Never Current Former Type _____ Started _____ Stopped _____

Do you exercise regularly None Minimal Moderate Heavy Active but no formal exercise

Do you use your seat belt? Yes No