

Patient History

Name: _____

DOB: ____ - ____ - ____

Primary Care Physician: _____

I do not have a primary physician.

Referred by: _____

VITALS: systolic # ___ diastolic # ___ position: _____ Time: _____

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

HEALTH SCREENINGS

- | | | | |
|-------------------------------|-----------------------------|--|---|
| Last Bone Density Test | Year: _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |
| Last Cholesterol Level | Year: _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |
| Last Colonoscopy | Year: _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |
| Last Diabetes Test | Year: _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |
| Last Mammogram: | Year: _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |
| Previous abnormal mammograms? | <input type="checkbox"/> No | <input type="checkbox"/> Yes, Year _____ | Treatment: _____ |
| Last Pap Smear: | Year: _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |
| Previous abnormal Pap smears? | <input type="checkbox"/> No | <input type="checkbox"/> Yes, Year _____ | Treatment: _____ |
| Last Thyroid Test | Year: _____ | <input type="checkbox"/> Normal | <input type="checkbox"/> Abnormal _____ |

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)

- Birth Control Pills Depo Provera Foam Tubal ligation
- NuvaRing IUD Condoms Vasectomy
- Ortho Evra Diaphragm Other _____

Breakthrough bleeding: Yes No Clots: Yes No

OBSTETRICAL HISTORY:

Pregnancies _____ Full-Term _____ Pre-term _____ Abortions _____ Miscarriages _____ Tubal Prgnancies _____ 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

Revised 05/30/07 MRH