Patient Health History

Today's Date: _____ Name: _____ Date of Birth: _____ Age: _____
Reason for Visit/Concerns: _____
Primary Care Provider: _____ Referred by: _____
Marital Status: ☐Single ☐In a Relationship ☐Married ☐Widowed ☐Divorced Partner's name: _____
Occupation: _____ Race/Ethnicity: _____ Preferred Pharmacy Location: _____
Medication Allergies/Reactions: _____
In the event of an emergency (i.e. childbirth, surgery) do you have any objections to blood transfusions? ☐ Yes ☐ No

Current Medications/Dose (including birth control, over-the-counter medications, herbs, and vitamins):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Menstrual History:
Age at first period? _____ How many days between periods? _____ How many days do you bleed? _____
Flow: ☐ Light ☐ Moderate ☐ Heavy ☐ Heavy with clots Pain with periods: ☐ None ☐ Mild ☐ Moderate ☐ Severe
First day of last period: _____ Birth control method: _____ Are you satisfied with this method? _____
Do you have irregular periods? ☐ Yes ☐ No List any problems with your periods: _____
Are you attempting pregnancy? ☐ Yes ☐ No How long have you been attempting? _____
If postmenopausal: What age did your periods stop? _____ Have you had any postmenopausal bleeding? ☐ Yes ☐ No

Pregnancy History: List all pregnancies, including miscarriages and/or abortions
Pregnancies___ Full-Term___ Pre-Term___ Abortions___ Miscarriages___ Tubal Pregnancies___ Multiple___ Living___

DOB	Weeks	Labor length	Infant's Birth Weight	Sex	Name	Delivery Type	Location	Complications

Sexual History:
Gender Identity: _____ Pronouns: _____ Sex Assigned at Birth: _____
Are you sexually active? ☐ Yes ☐ No Sexual Orientation (i.e. sex/gender of your sexual partners): _____
Any new partners in the last year? ☐ Yes ☐ No How long have you been with your current partner? _____
Do you want to be tested for STDs? ☐ Yes ☐ No HPV Vaccine Date: _____ Did you receive all 3 shots? ☐ Yes ☐ No
Date of last pap smear: _____ Results: _____
Have you had any previous abnormal Pap smears? _____ If so, when: _____ Treatment? _____

Gynecologic History: Please check if you have or have ever had:

- ☐ Colposcopy*
- ☐ Cervical Dysplasia
- ☐ Laser/Cryosurgery/Freezing/ Cone Biopsy/LEEP
- ☐ Genital Herpes
- ☐ Genital Warts (Condyloma)
- ☐ Cold Sores
- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Trichomonas
- ☐ Syphilis
- ☐ HIV/AIDS
- ☐ Pelvic Inflammatory Disease (PID)
- ☐ Cervical Cancer
- ☐ Endometriosis
- ☐ Uterine Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Ovarian Cancer
- ☐ Infertility
- ☐ Sexual Problems
- ☐ Painful Intercourse
- ☐ Lack of Sexual Desire
- ☐ Uterine Fibroids
- ☐ Fibrocystic Breast
- ☐ Ovarian Cyst
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Other: _____

*A colposcopy is an exam of the vagina and cervix. A colonoscopy is an exam of the rectum and lower bowel.

Personal Medical History: Please check if you have or have ever had:

- ☐ Acne
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bacterial Vaginosis
- ☐ Blood clots
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Excessive Hair Growth
- ☐ Gallstones
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Lupus
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Recurrent Urinary Infections
- ☐ Recurrent Yeast Infections
- ☐ Seizure
- ☐ Skin disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose veins

Do you have a history of abuse:
Physical: ☐ Yes ☐ No
Sexual: ☐ Yes ☐ No
Emotional: ☐ Yes ☐ No
Other: _____

Date of last:
Mammogram: _____
Colonoscopy*: _____
Cholesterol Test: _____
Bone Density Scan: _____

Do you feel safe at home/work? ☐ Yes ☐ No

List any other significant medical history. Please provide date and explanation: _____
_____

Surgical History: Please list surgery and date: _____
_____

Family Medical History: ☐ Check if you were adopted and do not know your family history

Please state which relatives (Maternal or Paternal) have had the following and their age at diagnosis:

- ☐ Breast Cancer _____
- ☐ Ovarian Cancer _____
- ☐ Uterine Cancer _____
- ☐ Colon Cancer _____
- ☐ Other Cancer _____
- ☐ Heart Attack _____
- ☐ High Blood Pressure _____
- ☐ Deep Vein Thrombosis _____
- ☐ Stroke _____
- ☐ Heart Disease _____
- ☐ Diabetes _____
- ☐ Thyroid Disease _____
- ☐ Osteoporosis _____
- ☐ Birth Defects or Other Genetic Disorders _____
- ☐ Endometriosis _____
- ☐ Fibroids _____
- ☐ Miscarriage _____
- ☐ Stillbirth _____
- ☐ Recurrent Issues with Anesthesia _____
- ☐ Other _____

Health Habits:

Tobacco use? ☐ Yes ☐ No Amount per day: _____ How long: _____ Plan to quit? ☐ Yes ☐ No
Alcohol use? ☐ Yes ☐ No Drinks per week: _____ How long: _____ Plan to quit? ☐ Yes ☐ No
Marijuana use? ☐ Yes ☐ No Amount per week: _____ How long: _____ Plan to quit? ☐ Yes ☐ No
Drug use? ☐ Yes ☐ No Type: _____ How long: _____ Plan to quit? ☐ Yes ☐ No
Amount of caffeine per day: _____ Do you use a seat belt? ☐ Yes ☐ No
Do you perform self-breast exams? ☐ Yes ☐ No If so, how frequently? ☐ Monthly ☐ Occasionally ☐ Rarely ☐ Never
Do you exercise?: ☐ Heavy (4+ days/wk) ☐ Moderate (2+ days/wk) ☐ Minimal (once/wk) ☐ None
What brings you joy? _____