Patient History Form

Full Name: ______________________________________ DOB:________________

Family Doctor/PCP: _________________________________

Address of Family Doctor/PCP:____

I attest that the information here is true and correct to the best of my belief.

____

Patient's Signature Date

ALLERGIES

Do you have any known medication allergies? ☐ NO ☐ YES __________________________

Please circle any other allergies: Contrast Dye Peanuts Latex Shellfish

Other allergies and reaction: ____

____

PAST MEDICAL HISTORY

(If you have EVER had any of these conditions, please indicate with an X or √)

Breast Conditions

____ Abnormal Mammogram (fill in below)
date:_________ result: ________________
____ Breast Cancer ☐ Left ☐ Right
____ Breast Implants
____ Fibrocystic Breasts
____ Other ____________________

Gyn Problems

____ Abnormal Pap Smear (fill in below)
date:______ circle treatment: colpo/LEEP/cryo
____ Cervical Cancer (Neoplasm)
____ Dysmenorrhea (Painful Menses)
____ Endometrial Cancer (Uterine)
____ Endometriosis
____ Fibroids
____ Herpes infection (circle below)
Type 1 (cold sores) or Type 2 (genitals)
____ Human Papilloma Virus Infection (HPV)
____ Ovarian Cancer
____ Ovarian Cysts
____ Pelvic Inflammatory Disease (PID)
____ Polycystic Ovarian Syndrome (PCOS)
____ Sexually Transmitted Disease (circle below)
Syphilis, Gonorrhea, Chlamydia / date: _____
____ Vaginal Cancer (Neoplasm)
____ Vulvar Cancer (Neoplasm)
____ Other ____________________

Heart/Circulation Conditions (Cardiovascular)

____ Congenital Heart Disease
____ Congestive Heart Failure
____ Coronary Artery Disease
____ CVA (Stroke)
____ Hypertension (High Blood Pressure)
____ Irregular Heart Beat
____ Mitral Valve Disorders (MVP)
____ Pulmonary Embolism (Blood Clot in Lung)
____ Thrombophlebitis (Blood Clot in Extremity)

Endocrine (Glandular) Disorders

____ Diabetes – Type I (Insulin-Dependent - youth)
_____ Diabetes – Type II (adult onset)
_____Gestational Diabetes (only when pregnant)
____ Pituitary Gland Disorder
____ Thyroid Disease: circle one: Hypo / Hyper
_____ High Cholesterol

Immune System Diseases

____ Chronic Fatigue Syndrome
____ Other ____________________

Gastrointestinal (GI) Problems

____ Colitis, Ulcerative
____ Crohn's Disease
____ Hepatitis A
____ Hepatitis B
____ Hepatitis C
____ Irritable Bowel Syndrome
____ Other ____________________

Blood (Hematologic) Disorders

____ Anemia
____ Bleeding Disorder
____ Clotting Disorder
____ Sickle Cell Trait or Disease
____ Thalassemia
____ Other ______________________________

Musculoskeletal Disorders

____ Arthritis
____ Arthritis, Rheumatoid
____ Joint Pain
____ Fibromyalgia
____ Osteopenia
____ Osteoporosis
____ Scoliosis
____ Systemic Lupus Erythematosus
____ Other ______________________________

Neurologic Disorders

____ Common Migraines
____ Headaches
____ Multiple Sclerosis
____ Seizure Disorder (Epilepsy)
____ TIA or Stroke
____ Other ______________________________

Psychiatric or Emotional Conditions

____ ADHD/ADD
____ Bipolar (Manic-Depressive)
____ Major Depression
____ OCD (Obsessive-Compulsive Disorder)
____ Postpartum Depression
____ Severe Anxiety or Panic Attacks
____ Other ______________________________

Respiratory (Lung) or ENT (Ear Nose Throat) Disorders

____ Asthma
____ COPD
____ Lung Cancer
____ Pneumonia - Recurrent
____ Sleep Apnea
____ Tuberculosis
____ Other ______________________________

Skin Conditions

____ Acne (severe)
____ Eczema
____ Hirsutism (excess hair growth)
____ Hospital acquired infection (MRSA)
____ Psoriasis
____ Other ______________________________

Urinary (Urological) Disorders

____ Calculus (Kidney Stones)
____ Pyelonephritis
____ Stress Incontinence
____ Urge Incontinence/Overactive Bladder
____ Urinary Tract Infections (UTI)
____ Other ______________________________

Genetic Disorders

____ Cystic Fibrosis
____ Muscular Dystrophy
____ Other ______________________________

Test / Visit	Date	Results
Pap smear		
HPV		
Annual exam		
Mammogram		
Colonoscopy		
DXA Bone Scan		

PAST SURGICAL HISTORY

(Please include any D&C, D&E, colposcopy, cryotherapy or colonoscopy)

Surgery	Date	Reason

MEDICATIONS / SUPPLEMENTS / VITAMINS YOU ARE CURRENTLY TAKING

Medication / Supplement / Vitamin	Dose	How Often	Start Date	Prescribed by

Primary Pharmacy Name ____ Phone # _______________________

Pharmacy Address ____

FAMILY MEDICAL HISTORY

If **ANY** close relative of yours - such as brothers, sisters, parents, other children, grandparent (maternal or paternal), or aunt or uncle - has EVER HAD or CURRENTLY HAS any of the problems listed below, please check yes and enter specific relationship to you.

Endometriosis ☐ Yes ☐ No Who: Be specific____
Uterine Fibroids ☐ Yes ☐ No Who: Be specific____
Breast Cancer ☐ Yes ☐ No Who: Be specific____
Colon Cancer ☐ Yes ☐ No Who: Be specific____
Heart Disease ☐ Yes ☐ No Who: Be specific____
High Blood Pressure ☐ Yes ☐ No Who: Be specific____
High Cholesterol ☐ Yes ☐ No Who: Be specific____
Blood Clots ☐ Yes ☐ No Who: Be specific____
Diabetes-Type I ☐ Yes ☐ No Who: Be specific____
Diabetes-Type II ☐ Yes ☐ No Who: Be specific____
Thyroid (Hyperthyroid) ☐ Yes ☐ No Who: Be specific____
Thyroid (Hypothyroid) ☐ Yes ☐ No Who: Be specific____
Lung Cancer ☐ Yes ☐ No Who: Be specific____
Bipolar Disorder ☐ Yes ☐ No Who: Be specific ____
Malignant Tumors ☐ Yes ☐ No Who: Be specific____
Ovarian Cancer ☐ Yes ☐ No Who: Be specific____
Uterine Cancer ☐ Yes ☐ No Who: Be specific____
Osteoporosis ☐ Yes ☐ No Who: Be specific____
Other ☐ Yes ☐ No Who: Be specific____

MENSTRUAL HISTORY

Age of first menstrual period ______________ Cycle length (28 days or ?): ____________
# of days bleeding with a period ____________ Period flow: Light Medium Heavy

Date of last normal menstrual period (first day): ______________________________
Birth control method currently using: ____

Age Menopause: _____ Status: PREMENOPAUSAL POSTMENOPAUSAL PERIMENOPAUSAL

SEXUAL HISTORY

Partner Preference? ☐ Male ☐ Female ☐ Both
How many sexual partners have you had in the past year? ____________
How long have you been with your current partner? ____________months/years (circle one)
Have you or your partner ever participated in oral intercourse? ☐ Yes ☐ No
Have you or your partner ever participated in anal intercourse? ☐ Yes ☐ No

PREGNANCY SUMMARY

Total Number of Pregnancies	**Full Term Births (> 37 wks)**	**Premature Births (< 37 wks)**	**Terminations**	**Miscarriage:** was surgery needed	**Ectopic Pregnancies:** Left or Right	**Number of Living Children**

New Patients Only!	Child's DOB	Child's Name	# weeks at Delivery	Hours in Labor	Birth Weight	M or F	Vaginal C-Section VBAC	Complications	Physician/ Location

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Alcohol Use: ☐ Never ☐ Current ☐ Former How Much:________ Age started:____ Age stopped:____

Illegal Drug Use: ☐ Never ☐ Current ☐ Former How Often:________ Age started:____ Age stopped:____
Which Drug(s): ____________________________ When last used: __________________

Tobacco Use: ☐ Never ☐ Current ☐ Former How Much:________ Age started:____ Age stopped:____

Caffeine Use: ☐ Never ☐ Current ☐ Former How Much:__________ Age started:____ Age stopped:____

Exercise Habits: ☐ Active but no formal exercise ☐ Sedentary

☐ Minimal (Once weekly) ☐ Moderate (1-3 times weekly) ☐ Heavy (4 or more times weekly)
Type of exercise: ____

Occupation: ____ **Employer:** ____