Health History Form

Patient Name: ____________________________
Date: ____________________________

Primary Care ____________________________
Referring Physician (if applicable) ____________________________

Why have you come to the office today?

____

____

Is this a new problem? ____________________________

When was your last pap smear? ____________________________
Have you ever had an abnormal pap smear? ____________ If so when? ____________
When was your last mammogram? ____________________________
When was your last colonoscopy? ____________________________
When was your last DEXA (Bone Density) scan? ____________________________

Menstrual History
When was the first day of your last menstrual period ______ / ______ / ______ ?
How many days from the first day of your period to the next first day? ____________
How many days do you bleed? ____________ Age periods began? ____________
Any recent changes in your periods? ____________________________
Are you periods painful? ____________________________
Are your periods heavy? ____________________________

Sexual History?
Have you ever had sex? ________ How many sexual partners have you had? ____________
Do you have pain with intercourse? ____________________________
Current method of birth control? ____________________________

Obstetrical History
How many pregnancies have you had? ____________________________
How many live births? ______ How many miscarriages? ______ How many terminations? ______

List each pregnancy below:

DATE	WEEKS PREGNANT	MALE OR FEMALE	VAGINAL OR C-SECTION	EPIDURAL	COMPLICATIONS

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Medical History
List any medical conditions that you have been diagnosed with
(Examples: asthma, COPD, thyroid dysfunction, high blood pressure, diabetes, high cholesterol, cancer, blood clots)

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____
____

Surgical History
List surgeries with dates of procedures

____
____
____

Allergies: ______________________________

MEDICATIONS	DOSE	FREQUENCY	REASON FOR MEDICATION

Family History
List any family members and ages of diagnosis with any of the following:
Breast Cancer______________ Colon Cancer______________
Uterine Cancer______________ Ovarian Cancer______________
High Blood Pressure______________ Diabetes______________
Heart Disease______________ Thyroid Dysfunction______________
Congenital Anomalies______________ Osteoporosis______________
Other Diseases______________

Social History
Occupation ______________________________
Marital Status: ______ Single ______Married ______ Divorced ______Widowed
Tobacco Use: ____ No ____ Yes ____ Packs Per Day Alcohol Use: ____ No ____Yes
Illegal Drug Use: ____No ____ Yes
Have you ever been sexually or physically abused?_____ No _____ Yes
Do you feel safe: _____No _____Yes