

PATIENT HEALTH & HISTORY

JEFFREY M. BLAKE, M.D., F.A.C.O.G.
Marilyn Hartwell-Frazier, R.N., M.S. ANP/GNP
141 W. 22nd Street, Suite 309
Anderson, IN 46016
Office 765-646-8569, Fax 765-622-9708
www.drjeffblake.com

Please fill out completely. Mail to the above address or e-mail within 3 days of receipt, otherwise, bring this to your appointment. Use additional sheets for surgery/medication lists as needed. Thank you.

Current date: _____

NAME: (last) _____ (first) _____ (middle) _____

Date of Birth: _____ Social Security #: _____

DESCRIBE PRESENT PROBLEM: (check here if there are no problems: _____)

SEXUAL HISTORY: Have you ever been sexually active? NO YES

Age at first intercourse: _____ Are you currently sexually active? NO YES

Please check any birth control methods ever used. Please circle current method.

___ oral contraceptive (brand _____)	___ IUD
___ condoms	___ foam
___ diaphragm	___ withdrawal
___ vasectomy	___ Essure
	___ rhythm (natural family planning)
	___ tubal ligation
	___ ablation
	___ Other _____

Have you ever had any of the following sexually transmitted diseases? (include date diagnosed and treated)

___ Chlamydia _____	___ Gonorrhea _____
___ Herpes _____	___ Syphilis _____
___ Trichomonas _____	___ Genital Warts _____
___ HIV _____	___ Other _____

How many partners have you had? _____ How many partners has your current partner had: _____

Any sexual problems? _____

MEDICAL HISTORY: Do you currently or have you ever had any of the following? Check all that apply.

___ Anemia	___ Arthritis	___ Cancer (type) _____
___ Diabetes	___ Gastric Ulcer	___ Heart disease/Rheumatic fever/Mitral valve prolapse
___ High Blood Pressure	___ High Cholesterol	
___ Kidney	___ Thyroid	___ Tuberculosis
___ Other _____		

Please explain and include description of medical illness, date diagnosed, and physician who treats(ed) you:

INFECTION HISTORY: Check all that apply.

___ Live with someone with TB or exposed to TB	___ Rash or viral illness since last menstrual period
___ History of HPV	___ History of Hepatitis B

SURGICAL HISTORY: Please list surgery/date/physician. Attach typed list w/patient name if available.

FAMILY HISTORY

__ alcoholism __ cholesterol __ clotting __ deep vein thrombosis __ diabetes __ high cholesterol __ high blood pressure
Other: _____

SOCIAL HISTORY (Circle appropriate answer):

Marital status: Married Single Divorced Widowed

Husband's name: (if applicable) _____

Tobacco use: (ever) NO YES ___ packs per day for ___ years. Quit date ___/___/___

Alcohol use: NO YES ___ drinks per day/ ___ drinks per week/ ___ drinks per month

Street drugs: NO YES Name(s) and last date used: _____

Have you ever been treated for an alcohol or drug problem? NO YES

Please describe: _____

MEDICATION HISTORY: (please attach typed list if available w/patient name)

NAME DOSE REASON Prescribed by: _____

ALLERGIES:

Do you have any allergies to the following? Please check all that apply and describe reaction:

Food:

___ Eggs ___ Milk ___ Peanuts ___ Tomatoes ___ Strawberries ___ Wheat ___ Other: _____

Medications:

___ penicillin _____ ___ sulfa _____

___ aspirin _____ ___ codeine _____

___ morphine _____ ___ other antibiotic or medication _____

Environmental:

___ Animal dander ___ Dust ___ Grasses ___ LATEX ___ Stainless steel ___ Talc ___ Tape ___ Topical Iodine Other: _____

MENSTRUAL HISTORY: Date of last menstrual period (LMP) or year, if post-menopausal: _____

Menstrual cycle: Age of onset _____ Regular? YES NO Is your flow: *Light Normal Heavy*

Duration of menstruation (# of days): _____ Duration of menstrual cycle (# of days): _____

If your periods are abnormal (circle all that apply): *bright red bleeding gushing clots (estimate size: _____)*

Other: _____

Do you experience pre-menstrual syndrome? NO YES

Check all that apply and describe symptom:

___ Hot flashes _____ ___ Irritability _____

___ Urine loss _____ ___ Decreased sexual desire _____

___ Insomnia _____ ___ Vaginal dryness _____

___ Vaginal discharge/itching/burning _____

Other: _____

PREGNANCY HISTORY: Total number of pregnancies: _____ Deliveries: _____ Miscarriages: _____

Elective Abortions: _____ Living children: _____

Please list pregnancies, in order, including miscarriages and abortions:

#	Delivery Date	Vaginal or c/section	Weight	Weeks	Gender (M/F)	Complications	Hospital/City

PHYSICAL HISTORY

Date of last physical exam: _____ Date of last PAP smear: _____ Date of last mammogram: _____ Date of last colonoscopy: _____

Please describe any abnormal PAP smear or mammogram (include dates): _____