PATIENT HEALTH & HISTORY

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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 ____rhythm (natural family planning)
___ diaphragm ___withdrawal ____tubal ligation
____vasectomy ___Essure ____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):_____
_____