

Health History (page 1 of 2)

Today's Date: _____

Name _____ Age _____ Birthdate _____

SOCIAL HISTORY/MEDICINES

Allergies (latex, medicine): _____

Current medications / doses _____

Occupation _____ Marital Status _____

Do you smoke? _____ Consume alcohol? _____ Use recreational drugs? _____

MEDICAL HISTORY

Family Doctor: _____

Have you had problems with the following:

	<u>Yes</u>		<u>Yes</u>
1. Eyes	_____	11. Skin	_____
2. Severe headaches	_____	12. Diabetes	_____
3. Heart/blood pressure	_____	13. Thyroid	_____
4. Circulation (varicose veins, stroke, phlebitis...)	_____	14. Gallbladder / pancreas	_____
5. Lungs (asthma, chronic bronchitis...)	_____	15. Nervous system (epilepsy, convulsions)	_____
6. Arms/legs (pain, numbness, fractures...)	_____	16. Depression / other mental illness	_____
7. Liver (hepatitis, mononucleosis...)	_____	17. Serious accidents	_____
8. Bladder / kidneys	_____	18. Serious illnesses / conditions / disabilities not listed	
9. Stomach / intestines (ulcers, colitis, hemorrhoids..)	_____	(list) _____	
10. Blood disorders (anemia, sickle cell, clotting problems)	_____	_____	

Date and Results of your last:

Mammogram _____

Cholesterol screening _____ Colonoscopy _____ Bone density scan _____

Prior Surgeries and Dates: _____

OB/GYN HISTORY

Have you had problems with:

	<u>Yes</u>
1. Breasts	_____
2. Uterus / cervix	_____
3. Fallopian tubes / ovaries	_____
4. Abnormal pap smears	_____
5. Vaginal infections	_____
6. Painful intercourse	_____
7. Sexually transmitted diseases	_____
8. Trauma / domestic violence	_____

Name _____

OB/GYN HISTORY (continued)

- 9. Age at first period _____
- 10. First day of last period _____
- 11. How many days do your periods last? _____
- 12. Do you have pain with your periods? _____
- 13. Are your periods regular? _____
- 14. Age at menopause _____
- 15. Total number of pregnancies _____
 Term _____ Pre-term _____ Miscarriage _____
 Abortion _____ Living children _____
- 16. Vaginal birth _____ C-Section _____
- 17. Complications of pregnancy / childbirth: _____

- 18. Current contraceptive method _____

FAMILY HISTORY

Problems in immediate family (mother, father, brother, sister, grandparent):

- | | <u>Yes</u> |
|---|------------|
| 19. Diabetes | _____ |
| 20. Heart / high blood pressure / stroke | _____ |
| 21. Kidneys | _____ |
| 22. Cancer | _____ |
| 23. Death before age 50? | _____ |
| 24. Osteoporosis | _____ |
| 25. Other major illnesses? | _____ |
| 26. Interviewer's comments / signature / date | _____ |
| _____ | |
| _____ | |
| _____ | |

Patient's Signature _____

Date _____