INITIAL HEALTH HISTORY FORM

Date _____

Legal Name _____ Age _____ Date of Birth _____

Reason for your visit _____

GENERAL MEDICAL HISTORY

	none	self	mother	father	sibling	your child	grandparent	aunt/uncle
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis/Lupus	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Blood disorder	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐
Mental disorder	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Seizure disorder	☐	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐	☐	☐

Do you smoke/use tobacco ☐ No ☐ Yes How many per day? _____

Do you drink alcohol? ☐ No ☐ Yes How many drinks per week? _____

Do you use recreational/illegal drugs? ☐ No ☐ Yes What and how long? _____

Have you had any surgery? List what surgeries you have had and the year you had it:

_____

_____

_____

What was the month and year of your last physical exam? _____

What the month and year of your last:

Pap test _____ never / normal / abnormal → If abnormal Pap, did you have a colposcopy? ☐ No ☐ Yes

Bone density _____ never / normal / abnormal Cholesterol _____ never / normal / abnormal

Colonoscopy _____ never / normal / abnormal Mammogram _____ never / normal / abnormal

INITIAL HEALTH HISTORY FORM

Patients Name _____ Date of Birth _____

☐ No know drug allergies ☐ Allergic to latex ☐ Allergic to tapes/adhesives

Allergic to _____ Reaction _____

Allergic to _____ Reaction _____

What Medications do you take? (Include birth control / hormones)

Prescription Medication Dose, # of times/day What is it for?

_____

_____

_____

_____

(If you take more than four prescription medications, please attach a separate sheet listing them.)

Do you take a multivitamin? ☐ No ☐ Yes Calcium supplement? ☐ No ☐ Yes

OB/GYNE MEDICAL HISTORY

How old were you when you had your first period? _____

How many days from the first day of one period to the first day of the next one? _____

How many days do your periods last? _____

Are your periods regular? ☐ No ☐ Yes

Do you have cramps with your period? ☐ No ☐ Yes: ☐ mild ☐ moderate ☐ severe

Do you bleed or spot between periods? ☐ No ☐ Yes

Do you bleed after intercourse? ☐ No ☐ Yes

What was the first day of your last period, or if you are menopausal, when was your last period? _____

Do you have menopausal symptoms? ☐ No ☐ Yes What? _____

How old were you when you first had sexual intercourse? _____

# of sexual partners _____

Are you sexually active now? ☐ No ☐ Yes

If yes, is your partner ☐ Male ☐ Female

Do you use anything to keep from getting pregnant? ☐ No ☐ Yes

Are you trying to get pregnant? ☐ No ☐ Yes

If yes, what? (circle) Condoms DepoProvera Pill Patch Ring Tubal Ligation Vasectomy

IUD inserted (date and type of IUD) _____ Diaphragm Spermicides Rhythm Withdrawl

Do you have: (circle) FIBROIDS ENDOMETRIOSIS POLYCYSTIC OVARIES HIGH RISK HPV

Gardasil series dates: 1st injection _____, 2nd injection _____, 3rd injection _____