

PATIENT HEALTH HISTORY

Dr. Ms. Mrs. Miss
 Name _____ last middle first

Single Divorced Married Widowed Date _____

Age _____ Date of birth _____ Birthplace _____

Occupation _____ All previous occupations _____

SSN _____ Education: _____ Years High School _____ Years College _____ Years Post Graduate _____

Medicare Number _____

Reason for today's visit: (please list all symptoms)

- _____
- _____
- _____
- _____
- _____

Please do not write in this space

Gynecology History

Menstrual Periods:

Age at onset _____

Regular Yes No

Cycle _____ days (from start of one period to start of next)

Usual duration _____ days

Heavy Medium Light

Pains or cramps Yes No

Date of last period _____

Age & Year in Which Periods Stopped

Permanently - Menopause (if applicable) _____

Age _____ Year _____

What do you use for birth control? _____

Do you have bleeding between periods? Yes No

Do you have bleeding after intercourse? Yes No

Do you have a vaginal discharge today? Yes No

Do you have urinary incontinence? Yes No

Pregnancies

How many pregnancies? _____

How many children born alive? _____

How many stillbirths? _____

How many premature births? _____

How many cesarean sections? _____

How many miscarriages? _____

How many abortions? _____

How many tubal pregnancies? _____

Any complications with any pregnancy? Yes No

Have you had a pap smear within the last year? _____

Was your last pap smear normal or abnormal? _____

When was your last mammogram? _____

What medicines do you take regularly? _____

Personal Medical History

Illness Have you ever had: (please check all that apply)

	Yes	No	Date
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary infection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____

	Yes	No	Date
Nervous or mental disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Venereal warts	<input type="checkbox"/>	<input type="checkbox"/>	_____
P.I.D.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	_____
German measles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (type)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:			_____

Allergies Are you allergic to:

Betadine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Novocaine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	_____
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any other drug(s):			_____

Injuries Have you had:	Yes	No	Date
Concussion or head injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Car accident injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever been knocked unconscious	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other: _____

Surgical History Have you had any of the following:

Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hernia operation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hemorrhoid operation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid operation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gall bladder operation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Varicose vein operation	<input type="checkbox"/>	<input type="checkbox"/>	_____
D & C	<input type="checkbox"/>	<input type="checkbox"/>	_____
Laparoscopy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tubal ligation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Removal of tube or ovary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other:			_____

PATIENT HEALTH HISTORY (CONTINUED)

X-rays

Have you ever had x-rays of:

			Date
Chest	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Stomach (upper G.I. series)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Gall bladder	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Kidneys	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Skull	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Colon (lower G.I. series)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

Do you currently smoke No Yes

_____ packs per day currently

_____ number of years

If not smoking now, have you ever smoked No Yes

How long has it been since you last smoked? _____

Do you drink alcoholic beverages No Yes

_____ number of drinks per week

Do you have any sexual concerns you would like to discuss?

Family History

	Age	If living - Please list ALL medical conditions and illnesses	Age at death	If deceased - please list cause of death
Father				
Mother				
Brother				
Brother				
Brother				
Sister				
Sister				
Sister				

Have any relatives ever had breast cancer? _____

Name of physicians that are familiar with your medical history: _____

PATIENT HEALTH HISTORY (CONTINUED)

Personal / Family History

Number of Siblings _____

History of:	PERSONAL			FAMILY	Number of Siblings		
	Yes	When	No		Yes	Specify Member	No
Abdominal Bleeding							
Allergies							
Anemia							
Arthritis							
Asthma/Emphysema							
Back Disorders							
Backache							
Black Tarry Stools							
Bleeding Diseases							
Blood in Stool							
Blood in Urine							
Cancer							
Change in Bowel Habits							
Chest Pain							
Colitis							
Constipation							
Convulsion							
Cough							
Coughing Blood							
Depression							
Diabetes							
Diarrhea							
Difficulty Swallowing							
Dizziness							
Enlarged heart							
Double Vision							
Epilepsy							
Fainting Spells							
Gallstones							
Gallbladder Disorder							
Glaucoma							
Headaches							
Heart Disease							
Heart Murmur							
Hepatitis							
Hoarseness							
High Blood Pressure							
HIV							
Indigestion							
Irregular Heart Beat							
Kidney Infection							
Kidney Stone							
Leg Pain							
Lung Disease							
Nocturia							
Nosebleeds							
Nervous Disorder							
Painful Urination							
Paralysis							
Phlebitis							
Pleurisy							
Pneumonia							
Pus in Urine							
Rheumatic Fever							
Shortness of Breath							
Stroke							
Swelling of Feet							
Swollen/Painful Joints							
T.B.							
Thyroid Disease							
Ulcer							
Venereal Disease							
Vomited Blood							
Other							

PATIENT HEALTH HISTORY (CONTINUED)

Personal Habits

Please answer honestly. This information is needed to assure the best possible treatment.

All information is **confidential**. Please rate your answer on a scale of 1 to 5, with 1 being No/Never and 5 being Yes/Often.

	1	2	3	4	5	Elaborate
Exercise Regularly (3 to 4 X WK)						
Wear Seat Belts						
Use Drugs						
Drink Alcohol						
Smoke						
Chew Tobacco						
Experience Stress						
Other						

Women Only

Menstrual Periods: Age Onset _____ Regular? _____ Date Last Period Began _____

Age of Menopause: _____

Difficulty with Periods? Yes No Specify _____

Pregnancies: _____

No. of Children: Born Alive _____ Cesarean _____ Premature _____ Stillborn _____ Miscarriages _____

Describe Complications: _____

Have you ever been referred to a specialist? No Yes Please Elaborate

Have you ever been in an accident? No Yes Please Elaborate

Are there any environmental risks involved in your job or home environments? No Yes Please Elaborate

Military Service

Which branch of service did you serve in? _____

Length of enlistment: _____ From _____ To _____

Did you sustain any injuries? No Yes Please Elaborate

