Patient Data Label

INITIAL HISTORY

MARITAL STATUS:
☐ SINGLE ☐ MARRIED ☐ WIDOWED
☐ DIVORCED / SEPARATED ☐ OTHER

A. REVIEW OF SYSTEMS:

YES	NO	GENERAL
		1. My health is generally good
		2. Unexplained weight loss or gain of more than 10 lbs
		3. Night sweats/hot flashes
		4. Cancer. If yes, where/when?
		5. Smoke cigarettes. If yes, # per day # of years
		6. Alcohol use. If yes, how many drinks/week?
		7. Are you breast feeding now?
		8. Birth defects or genetic problems
		9. Are you being treated for any illness/condition now? If yes, what?
		10. Do you currently take medicines, prescription, over-the-counter or herbal? If yes, name:
EYES		
		11. Eye problems (except glasses or contacts)
EARS/NOSE/MOUTH/THROAT		
		12. Hearing problems
		13. Frequent nosebleeds
		14. Frequent sore throat
CARDIOVASCULAR		
		15. Mitral valve prolapse
		16. Heart murmur
		17. Varicose veins
		18. Blood clots (head/leg/lungs)
		19. Stroke or stroke-like problems
		20. High blood pressure
		21. High cholesterol
RESPIRATORY		
		22. Chronic cough or other breathing problems/asthma
		23. Tuberculosis or exposure to tuberculosis
GASTROINTESTINAL		
		24. Stomach or bowel problems
		25. Liver problems (hepatitis or tumor, etc.)
		26. Gallbladder problems
GENITOURINARY		
		27. Breast lump or breast discharge
		28. Uterine Fibroids
		29. Ovarian cysts
		30. Bladder or kidney problems
		31. Vaginal discharge that itches/burns or has a bad odor
		32. Endometriosis
		33. Pain with sex
		34. Previous pap. When? Normal ☐ Abnormal ☐ *Any previous abnormal paps? Yes ☐ No ☐ *Any Cervical Treatments? Which?
		35. Did your mother take DES when she was pregnant with you to prevent a miscarriage?
		36. History of sexually transmitted infection, Check type(s): ☐ Chlamydia ☐ Gonorrhea ☐ Genital warts ☐ Herpes ☐ Syphilis ☐ PID ☐ Hepatitis B ☐ HIV
MUSCULOSKELETAL		
		37. Arthritis or osteoporosis
SKIN		
		38. Acne or other skin problems. What?
NEUROLOGICAL		
		39. Migraine headaches (diagnosed by Dr/NP/PA)
		40. Seizures/epilepsy
		41. Numbness in arms/legs (recurring)

A. REVIEW OF SYSTEMS:

YES	NO	PSYCHOLOGICAL
		42. Depression, requiring treatment
ENDOCRINE		
		43. Thyroid problems
		44. Diabetes
HEMATOLOGICAL/LYMPHATIC		
		45. Anemia
		46. Sickle cell disease/trait
		47. blood clotting disorder
IMMUNOLOGY		
		48. Rubella (German measles)
		49. Vaccine for Rubella (German measles)
		50. Tetanus immunization. Date?
		51. Hepatitis B immunization. Dates?
		52. Varicella (Chicken Pox). Date?
		53. HPV Vaccine. Dates?
		54. Others?
RHEUMATOLOGY / AUTOIMMUNE DISEASES		
		55. LUPUS / SLE
		56. Other?

B. HOSPITALIZATION AND SURGERIES

Year	Reason

C. FAMILY HISTORY

Are you adopted? Yes ☐ No ☐

Have your biological family (parents, brothers, sisters) had any of the following?

YES	NO	DIAGNOSIS	RELATIVE
		Osteoporosis	
		Diabetes	
		Heart attack/stroke before age 50	
		High blood cholesterol or fats	
		Genetic problems	
		Cancer	
		High blood pressure	
		Blood clots/deep vein thrombosis	

ALLERGY

Are you allergic to any drug, medication, latex or other substance, including local anesthesia? Yes ☐ No ☐

If yes, what?

STAFF COMMENTS / EXPLANATIONS (by number)

PLEASE COMPLETE OTHER SIDE ➔➔➔➔

(Rev. 04/2010)

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D. PREGNANCY HISTORY

☐ Never Pregnant

DELIVERED					ABORTION / MISCARRIAGE			
Mo.	Yr.	Vag.	C-Sec.	Birth Weight	Yr.	Wks.	Spont.	Induced

E. CONTRACEPTIVE HISTORY

Current birth control method:

How long used:

Any problems with this method? Yes ☐ No ☐

If yes, what:

What method do you want to use now?

Are you planning a pregnancy in the NEXT year? Yes ☐ No ☐

Which of the following METHODS have you used in the past:

YES	NO	METHOD	COMMENTS / PROBLEMS
		Abstinence	
		☐ Tubal ☐ Vasectomy	
		Oral Contraceptives	
		Implant – ☐ Norplant ☐ Implanon	
		Depo-Provera (injection)	
		Lunelle (injection)	
		IUD – ☐ Mirena ☐ ParaGard	
		Patch	
		Ring	
		Condoms	
		☐ Diaphragm ☐ Cap	
		Sponge	
		Natural Family Planning	
		Withdrawal	

F. SOCIAL HISTORY

YES	NO	HAVE YOU RECENTLY EXPERIENCED:	COMMENTS
		☐ Emotional ☐ Relationship problems	
		Thoughts of suicide	
		Death of ☐ family member ☐ friend	
		☐ Job loss ☐ Financial problems	
		Problems in living arrangements / school	
		☐ Legal problems ☐ arrests ☐ divorce	
		Parental problems	
		Are you physically abused?	
		Has anyone forced you to have sex?	
		Are you sexually abused?	
		Are you afraid of your: ☐ partner ☐ family member(s) ?	
		Who helps and supports you with your problems?	

G. MENSTRUAL HISTORY

1) Age periods began:

2) Number of pads/tampons used on heaviest day:

3) Length of period: (days)

4) Are your periods usually regular? Yes ☐ No ☐

5) Last period started on (date):
It seemed: ☐ Normal ☐ Not normal

6) Do you experience, before or with periods: ☐ cramps ☐ bloating ☐ bowel problems ☐ emotional changes

7) Do you have vaginal bleeding after sex? Yes ☐ No ☐

8) Do you have vaginal bleeding between menstrual periods: Yes ☐ No ☐

STI / HIV RISKS

Number of sex partners in your life - MALE: FEMALE:

How many sex partners have you had during the past year?

How old were you when you started having sex?

Sexual Activity - Check Type(s): ☐ Vaginal ☐ Oral ☐ Anal

YES	NO		COMMENTS
		Have you ever used street drugs? If yes, when?	
		Have you received blood or blood products since 1978?	
		Was any partner: ☐ a street drug user ☐ a Hemophiliac, or ☐ infected with HIV / AIDS?	
		Have you shared needles? Example: Injecting drugs, tattooing, piercing?	

COMMENTS

To the best of my knowledge the information I have provided is correct and complete.

Client Signature **Date**

Staff Signature **Date**

History Reviewed:

Staff Signature Date

Staff Signature Date

Staff Signature Date

Staff Signature Date