

Allergy Label
NKDA

Patient Label

ANNUAL/PAP HISTORY FORM (Page 1)

Name: _____

Reason for visit: _____

Allergies: No Known Allergies Drug Allergies: _____ Seasonal Allergies Other: _____

When I get this allergy I have these symptoms: hives nausea vomiting rash other: _____

List all medications or drugs you are taking (including over-the-counter medications/herbal medications/vitamins/birth control) :

List all other sources of healthcare: _____

General Health Questions

When did your last menstrual period start? ___/___/___

When was your last pap smear? _____ at time of physical exam

When was your last physical exam? _____

Have you ever had an abnormal Pap? YES NO

Did you have a breast exam at that time? YES NO

When was your last mammogram (if > 40 yrs old)? _____ N/A

REVIEW OF SYSTEMS Have you had or do you now have any of the following (please check yes or no for each item):

1. General

Yes No

- My health is generally good
- Recent ≥ 10 lb weight gain or loss
- Night sweats/hot flashes
- Cancer _____
- Stroke
- Blood transfusion or organ transplant before 1992
- In utero exposure to DES
- Future surgery scheduled that requires long-term bed rest

2. Immunizations

- Measles, Mumps and Rubella vaccine (MMR)
- Hepatitis B vaccine
- HPV Vaccine

3. Cardiovascular

- Mitral Valve Prolapse
- Palpitations/Heart Murmur
- Chest Pain
- High cholesterol
- High Blood Pressure

4. Neurological

- Severe headaches (not migraine)
- Persistent numbness, tingling
- Seizures/Epilepsy
- Diagnosed migraines

Yes, migraine with vision changes that:

- Start before the headache
- Last up to one hour
- Resolve before the headache begins

5. Gastrointestinal

Yes No

- Stomach or bowel problems
- Kidney/Adrenal Disease
- Liver Disease

6. Eyes

- Eye problems (other than glasses or contact lenses)

7. Musculoskeletal

- Arthritis

8. Respiratory

- Chronic cough
- Breathing problems/Asthma

9. Hematologic

- Anemia/low iron
- Bleeding Disorder/bruise easily
- Blood clots in legs or lungs
- Hemophilia-treated before 1987

10. Genitourinary

- Bladder/kidney/urinary problems
- Current urinary problems
- Uterine Fibroids/growths
- Sexually transmitted infections:

CIRCLE: Chlamydia, Gonorrhea, Herpes, HIV, Syphilis, Genital Warts, Other

- Pelvic Inflammatory Disease (PID)
- Vaginal infections/symptoms

Breast

Yes No

- Breast lump or nipple discharge
- History of breast mass

11. Skin

- Acne
- Chronic rash
- Allergies or irritants
- Other skin problems _____

12. Endocrine

- Thyroid problems
- Diabetes/gestational diabetes

13. Ears, Nose, Throat, Mouth

- Hearing problems
- Frequent nosebleeds
- Frequent sore throat

14. Psychology

- Depression
- Severe long-term depression
- Anxiety or mood swings
- Under the care of a psychiatrist/therapist

15. Genetics

- Genetic abnormalities _____

Comments/Other: _____

FAMILY HISTORY If you are ADOPTED & do not know your family's medical history, check here & skip this section.

Indicate which people in your family have had any of the following illnesses (F)ather, (M)other, (B)rother, (S)ister

- ____ Blood clot(s) ____ Stroke, Heart Attack, Heart Disease; age of onset: _____
- ____ Diabetes ____ Breast, Ovarian or Uterine Cancer; age of onset: _____
- ____ High Cholesterol ____ Other Cancer _____
- ____ High Blood Pressure ____ Inherited conditions: _____
- ____ Maternal use of DES ____ Osteoporosis (brittle bones)
- ____ Other ____ NO SIGNIFICANT PAST MEDICAL HISTORY

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ANNUALPAP HISTORY FORM (PAGE 2)

SEXUAL HISTORY

Yes No

Do you identify as Male Female Transgender

Have you had sexual intercourse? If yes, age at first intercourse? _____

Are you currently in sexually active?

If yes, is your sexual contact: all that apply: Vaginal Anal Oral

If yes, do you currently have one partner more than one partner

As far as you know, do(es) your partner(s) have one partner more than one partner

Are your partner(s) all that apply Male Female Transgender

I use condoms. Always Sometimes Never

Have you had more than 1 partner in the past year?

Not sure Do you want to be tested for sexually transmitted infections (STI's) including HIV?

Are you now or have you ever been afraid in any of your relationships?

Are you now or have you ever been harmed physically or emotionally in any of your relationships?

SOCIAL HISTORY

Yes No

Do you smoke or use tobacco? If so, how much per day? _____ How long? _____

Do you drink alcohol? If so, how often/how much? _____

Do you have concerns about alcohol or drug use?

Have you or your partner ever used street or IV drugs? If so, what? _____

Do you have concerns about your weight or eating habits that you would like to discuss today?

Do you exercise regularly?

Would you say you have a balanced diet, including getting enough Calcium and Folic Acid?

Do you feel you have a good support system with your friends and/or family?

MENSTRUAL HISTORY How long does your period usually last? _____ How old were you when your periods started? _____

Yes No

Was your last menstrual period on time and normal?

Are your periods regular?

Have you had intercourse without any protection, including a condom, since your last period?

Yes No

Are you concerned that you could be pregnant?

Do you bleed between periods?

Do you have severe cramps with your periods?

Do you have severe PMS symptoms?

CONTRACEPTIVE HISTORY

Yes No N/A

If/ when you have intercourse, do you use a method of birth control? If so, what _____

Would you like information about other methods? If yes, which _____

Have you or your partner had a tubal ligation or sterilization? If yes, which? _____

Are you interested in obtaining a method of birth control today? If yes, what? _____

PREGNANCY HISTORY Never pregnant (skip to the next section) Currently pregnant

of: Total Pregnancies _____ Deliveries _____ (age and # of children) Vaginal deliveries _____

Caesarean _____ Miscarriages _____ Stillbirths _____ # of Ectopic (tubal) pregnancies _____ Abortions _____

Yes No

Are you planning future pregnancies?

Are you breast feeding now?

All patients please sign and date the bottom of this page.

To the best of my knowledge, the information on this history form is complete and correct.

Patient signature _____

Reviewers Initials: _____

Date: ___/___/___

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