

History

Date: ___/___/___

A. MEDICAL HISTORY:	
YES	NO
GENERAL	
	1. My health is generally good
	2. Unexplained weight loss or gain of more than 10lbs in the past year
	3. Night sweats/hot flashes
	4. Cancer. If yes, where/when?
	5. Tobacco use. Number of years: If yes, <input type="checkbox"/> smoking. How many/day? <input type="checkbox"/> chewing tobacco?
	6. Alcohol use. If yes, how many drinks/week?
	7. Are you being treated for any illness/condition now? If yes what?
	8. Do you currently take medicine prescription, over the counter or herbal? If yes, name: Do you take any folic acid supplements?
	9. Birth defects or genetic problems
	10. Eye problems (except glasses or contacts)
	11. Hearing problems
	12. Frequent nosebleeds
	13. Frequent sore throat
CARDIO-RESPIRATORY	
	14. Mitral Valve Prolapse
	15. Heart murmur
	16. Varicose veins
	17. Blood clots (head/leg/lungs)
	18. Stroke or stroke-like problems
	19. High blood pressure
	20. High cholesterol
	21. Chronic cough or other breathing problems/asthma
	22. Tuberculosis or exposure to tuberculosis
GASTROINTESTINAL	
	23. Stomach or bowel problems
	24. Liver problems (hepatitis or tumor, etc.)
	25. Gallbladder problems
GENITOURINARY	
	26. Bladder, urine leaks or kidney problems
	27. Uterine fibroids
	28. Ovarian cysts
	29. Breast lump or nipple discharge or surgery
	30. Vaginal discharge that itches/burns or has a bad odor
	31. Endometriosis
	32. Pain with sex / Other sex problems
	33. Previous abnormal pap. If yes, when?
	34. If you were born before 1972, did your mother take DES when she was pregnant with you to prevent a miscarriage?
	35. History of sexually transmitted infection. Check type: <input type="checkbox"/> chlamydia <input type="checkbox"/> gonorrhea <input type="checkbox"/> genital warts <input type="checkbox"/> herpes <input type="checkbox"/> syphilis <input type="checkbox"/> PID
	36. Do you have vaginal bleeding after sex?
	37. Do you have vaginal bleeding between menstrual periods?
MUSCULOSKELETAL	
	38. a. <input type="checkbox"/> arthritis <input type="checkbox"/> osteoporosis <input type="checkbox"/> Other: _____ b. <input type="checkbox"/> lupus
SKIN	
	39. <input type="checkbox"/> Acne or other skin problems. If yes, what? _____ <input type="checkbox"/> Tattoo <input type="checkbox"/> piercing. If yes, Where? _____
NEUROLOGICAL	
	40. Chronic headaches
	41. Migraine headaches /Aura (diagnosed by Dr./NP/PA)
	42. Seizures/epilepsy
	43. Numbness in arms/legs (recurring)

A. (cont'd) MEDICAL HISTORY			
YES	NO		
PSYCHOLOGICAL			
	44. Depression requiring treatment. Have you ever considered suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No Other psychological problems?		
ENDOCRINE			
	45. Thyroid problems		
	46. Diabetes		
HEMATOLOGICAL/LYMPHATIC			
	47. Anemia (Low Iron)		
	48. Sickle cell disease / trait		
	49. Blood clotting disorder		
ALLERGY			
	50. Are you allergic to any drug, medication, latex or other substance, including local anesthesia? If yes, to what? Type of reaction:		
IMMUNIZATION (For multiples in a series, check the ones you have received)			
	51. Diphtheria		
	52. Hepatitis A		
	53. Hepatitis B: <input type="checkbox"/> shot 1 <input type="checkbox"/> shot 2 <input type="checkbox"/> shot 3		
	54. Human Papillomavirus (HPV): <input type="checkbox"/> shot 1 <input type="checkbox"/> shot 2 <input type="checkbox"/> shot 3		
55. Measles/Mumps/Rubella (MMR)			
	56. Meningococcal		
	57. Pneumococcal		
	58. Tetanus		
	59. Varicella (chicken pox)		
	60. Other:		
B. HOSPITALIZATION AND SURGERIES			
Year	Reason		
C. FAMILY HISTORY			
Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have your biological family (parents, brothers, sisters, grandparents) had any of the following?			
YES	NO	Diagnosis	Relative
		Osteoporosis	
		Diabetes	
		Father or brother had heart attack before age 55	
		Mother or sister had heart attack before age 65	
		Father or brother had stroke before age 55	
		Mother or sister had stroke before age 65	
		Cancer If yes, was the cancer: <input type="checkbox"/> Ovarian <input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Other Gynecological	
		High blood cholesterol	
		Genetic problems	
		Blood clots(DVT) or clotting disorder	
		Other:	
ADDITIONAL COMMENTS / EXPLANATIONS (by number)			

PLEASE COMPLETE OTHER SIDE

PLACE PATIENT LABEL HERE

D. PREGNANCY HISTORY	
<input type="checkbox"/> never pregnant If you have ever been pregnant, please list the number of live births _____ miscarriages _____ abortions _____ ectopic/tubal pregnancies _____	
E. CONTRACEPTIVE HISTORY	
Current birth control method: _____ How long used: _____ Any problems with this method? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, What: _____ What method do you want to use now? _____ Total number of children desired: _____ Are you planning a pregnancy in the NEXT year? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, what would you do if you become pregnant within the NEXT year? _____ Are you breastfeeding now? <input type="checkbox"/> Yes <input type="checkbox"/> No WHICH OF THE FOLLOWING METHODS HAVE YOU USED IN THE PAST	
METHOD	COMMENT/PROBLEM
<input type="checkbox"/> Abstinence	
<input type="checkbox"/> Tubal <input type="checkbox"/> Vasectomy <input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Birth Control Pills	
<input type="checkbox"/> The Patch	
<input type="checkbox"/> The Ring	
Implant: <input type="checkbox"/> Norplant <input type="checkbox"/> Implanon	
<input type="checkbox"/> Depo-Provera (The Shot)	
<input type="checkbox"/> IUD	
<input type="checkbox"/> Condoms	
<input type="checkbox"/> Diaphragm <input type="checkbox"/> FemCap	
<input type="checkbox"/> Lead's Shield	
<input type="checkbox"/> Sponge <input type="checkbox"/> Spermicide	
<input type="checkbox"/> Rhythm	
<input type="checkbox"/> NFP (Natural Family Planning)	
<input type="checkbox"/> Withdrawal	
F. SOCIAL HISTORY	
1. Are you physically abused? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Has anyone forced you to have sex? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Are you sexually abused? <input type="checkbox"/> Yes <input type="checkbox"/> No 4. Are you afraid of your <input type="checkbox"/> partner? <input type="checkbox"/> family member? 5. Are your parents aware of your visit here today? (if under 18 years old) <input type="checkbox"/> Yes <input type="checkbox"/> No 6. How often do you exercise? <input type="checkbox"/> Daily <input type="checkbox"/> about 3 times a week <input type="checkbox"/> weekly <input type="checkbox"/> occasionally <input type="checkbox"/> never 7. What's your occupation _____ 8. Last year of school completed (choose one): Middle School: <input type="checkbox"/> 7 th grade <input type="checkbox"/> 8 th grade High School: <input type="checkbox"/> freshman <input type="checkbox"/> sophomore <input type="checkbox"/> junior <input type="checkbox"/> graduated College: _____ <input type="checkbox"/> freshman <input type="checkbox"/> sophomore <input type="checkbox"/> junior <input type="checkbox"/> graduated <input type="checkbox"/> masters or higher	
G. MENSTRUAL HISTORY	
1. Age periods began: _____ 2. Number of pads/tampons used on heaviest day: _____ 3. Length of period: (days). # of days between periods: _____ 4. Are your periods usually regular? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Last period started on: _____ It seemed: <input type="checkbox"/> normal <input type="checkbox"/> not normal 6. Do you experience, before or with periods: <input type="checkbox"/> cramps <input type="checkbox"/> bloating <input type="checkbox"/> bowel problems <input type="checkbox"/> emotional changes 7. Age of first vaginal intercourse? _____	

PLACE PATIENT LABEL HERE

H. STI / HIV RISKS	
How many sex partners have you had during the past year? _____ Your sex partners are: <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> both	
Does your partner have sex with: <input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> both? Do you have (check all that apply): <input type="checkbox"/> vaginal <input type="checkbox"/> oral <input type="checkbox"/> anal sex?	
COMMENTS	
Have you ever used street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____	Have you received blood or blood products prior to 1978? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever shared needles? <input type="checkbox"/> Yes <input type="checkbox"/> No Example: Injecting drugs, tattooing, piercing? _____
STAFF COMMENTS (do not write anything in this space)	
To the best of my knowledge the information I have provided is correct and complete.	
Client Signature _____	Date _____
Staff Signature _____	Date _____
Annual History reviewed:	
Staff Signature _____	Date _____
Staff Signature _____	Date _____