HEALTH HISTORY

PATIENT NAME_____ **DOB**_____/_____/_____ **AGE**_____

Preferred Pharmacy: _____ Family Doctor_____Reason for visit _____

TO MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY

Staff use **VITALS:** **Height: ____ft ____in Weight: ___lbs, BP _____, Temp: ___ , RR:___, Pulse: __**

1. **PAST MEDICAL HISTORY** – Have you ever had the following: **_Patient denies any history**

__ Last Annual _____	_ Gastro Disorder _____	_ Renal Disease_____
__ Abn Pap smear _____	_ Headaches _____	__ Anxiety _____
__ Anemia _____	_ Heart Disease _____	__ Depression_____
__ Arthritis _____	_ High Cholesterol _____	__ Seizures _____
__STD'S _____	- Hypertension _____	__ Chicken Pox _____
__PMS _____	_ Thyroid_____	__ Rubella _____
__ Cystocele _____	_ Cancer_____	__ MRSA_____
__ Rectocele _____	_ DVT_____	__ Traumatic Injury _____
__ Endometriosis_____	Diabetes_____	
__ Fibroids _____	_ Respiratory disease _____	_ any other disease _____

2. **PAST SURGICAL HISTORY** – Have you ever had the following: **_ Patient denies any surgeries**

Please list all serious illnesses, operations & other hospitalizations you have experienced

Appendix _____ _	C-Section _____	Hysterectomy _____
Bladder Surgery_____	D&C _____	Joint Surgery _____
Breast Surgery _____	Gallbladder _____	Tubal Ligation _____
Cosmetic _____	Heart surgery _____	Other Surgeries _____
Gastric Surgery_____	Hernia Surgery_____	Major Fractures

3. **MEDICATIONS:** Please list all **medicines** you are currently taking **_ Patient denies taking any**

CURRENT MEDICATIONS:	DOSAGE (mg)	how often per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Please list all **ALLERGIES** (food, drugs, and environment) **_ Patient denies any Allergies**

_____ _____

_____ _____

_____ _____

__ Last Pap Smear _____ __Last Mammo _____ __ last Colonoscopy _____
__ Last Dexa Scan _____ __ Last Tetanus _____ __ Last Vaccinations _____

5. FAMILY HISTORY: Has any blood relative had any of the following: (Check box, leave blank if uncertain)

Denies family history_____

	Relationship		Relationship
□ **Breast** Cancer	_____	□ High Blood Pressure	_____
□ Colon Cancer	_____	□ Osteoporosis	_____
□ GYN Cancer	_____	□ Birth defects	_____
□ Diabetes	_____	□ bleeding Disorder	_____
□ Heart Disease		□ Stroke	_____

6. Menstrual History:

Age of 1st period # _____ Days between period # ____

Flow: □ ❑ light ❑Medium ❑ Heavy

Total days on period # _____ Last Period _____

Method of Birth Control _____ Clot Yes/No

Menopause Status _____ Age Menopause #_____

Breakthrough bleeding Yes___/No____ Hormone Replacement Therapy Yes___ /No____

7. Pregnancy:

Total pregnancy #_____ Full Term # _____ Premature #_____ Terminated # _____

Miscarriages # _____ Ectopic # _____ Multiple # _____ Living # _____

Pregnancy details:

Date	Birth Wt	Sex	Type of delivery	Complications	Doctor

8. SOCIAL HISTORY:

Marital Status: ❑ Single ❑Engaged ❑ Married ❑ Widowed ❑ Divorced ❑ Partner

Number of sexual partners in the last year_____

Education Level_____ Caffeine per day_____ Last Flu Shot_____

Tobacco: ❑ never ❑ minimal ❑ yes (___packs/day x ___ yrs) ❑ quit ___yrs ago (___packs/day x ___ yrs)

Alcohol: ❑ never ❑ minimal ❑ less than 10 per week ❑ more than 10 per week

Illicit drug ❑ No ❑ Yes what type: _____

Do you exercise? ❑ No ❑ Yes Occupation: _____

REVIEW OF SYSTEMS:

DO YOU HAVE NOW OR HAD ANY OF THE BELOW PROBLEM WITHIN THE <u>PAST YEAR</u>:
(Please circle)

Constitutional:	body aches	night sweat	Weight changes	
Eyes:	impaired vision			
HENT:	headaches	sinus congestion		
Breast:	lump	swelling	nipple discharge	tenderness
Cardiovascular:	chest pain	irregular heartbeats	fainting	
Respiratory:	coughing	shortness of breath	wheezing	
Gastrointestinal:	diarrhea	nausea/vomiting	constipation	blood in stool
Genitourinary:	urgency	frequency	painful urination	leaking urine
	Menstrual problems	painful intercourse	genital sores	
Skin:	rash,	change in skin lesions	or moles	
Neurological:	tingling	numbness,	muscular weakness	incoordination
Musculoskeletal:	back pain	joint pain	muscle pain	
Endocrine:	frequent urination,	excessive thirst,	cold/heat intolerance,	fatigue
Psychiatric:	anxiety,	depression	difficult sleeping	eating disorder
Heme-Lymph:	easy bleeding	easy bruising	swollen glands	
Allergic- Immu:	Sinus allergies	frequent illnesses		

Signature of Patient or parent if minor **Date**

1/02