



PATIENT HEALTH HISTORY

Please fill out the following questionnaire and bring it with you to your appointment. This information is very important to your health. Please take time to fill out this information fully and completely.

Name _____ D.O.B. _____ Age _____
FIRST M.I. LAST

Address _____

City _____ State _____ Zip _____

Phone Number (H) _____ (C) _____ Email _____

Occupation _____ Highest Degree Completed _____

Gynecologic History

Age of first menstrual period _____ Your last menstrual period started _____

Days between periods (1st day to 1st day) _____ Length of each period _____

Greatest number of pads or tampons used per day _____

Date of last PAP smear _____ Any history of abnormal PAP smears? _____

Date of last mammogram _____ Any history of abnormal mammogram? _____

Age of first intercourse _____ Sex with (check one) Men Women Both

Current method of birth control _____

Sexually transmitted disease history (check conditions you have or have had in the past):

- Gonorrhea Chlamydia Trichomonas Hepatitis Herpes Simplex Virus
- Syphilis HIV Warts Human Papilloma Virus

Any gynecologic surgery (e.g. tubal ligation, D&C, hysterectomy)

Year	Procedure
_____	_____
_____	_____
_____	_____

GYN Disorders (check symptoms you have or have had in the past)

- Abnormal bleeding Cramps Pain with Intercourse Vaginal Discharge Breast Lump
- Breast Pain Breast Discharge Infertility Hot Flashes Urine Leakage

Obstetric History

Have you ever been pregnant? Yes No If no, please skip to next section.

How many times have you been pregnant? _____ Any complications? _____

Please indicate pregnancy history:

Normal vaginal delivery _____ Cesarean section _____

Miscarriage _____ Abortion _____

Ectopic pregnancy _____ Premature Delivery _____

Past Medical History

Do you have any major medical problems such as (check all that apply):

- Diabetes Seizures Asthma High Blood Pressure Thyroid Problems Cancer Stroke Anemia
- Blood Clots Depression Anxiety Psychiatric Disorders High Cholesterol Heart Disease
- Kidney infection/stones Liver Disease Anorexia/Bulimia Stomach, Intestinal Disorders, GERD Lung Disease
- Other Problems and/or details: _____

Hospitalizations: If you have ever been hospitalized for an operation or serious illness (except OB/GYN), please list below:

Year	Illness or Operation	Complications (if any)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SYMPTOMS (check symptoms you currently have or have had in the past year that are persistent or severe)

- | | | | |
|--|---|---|--|
| <p>General</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats <p>Muscle/Joint/Bone</p> <p>Pain, weakness in:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders | <p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal | <p>Eye, Ear, Nose, Throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Last eye exam _____ <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Halos <input type="checkbox"/> Vision - Flashes <p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in mole <input type="checkbox"/> Rash <input type="checkbox"/> Loss of vision <input type="checkbox"/> Faint/loss of consciousness | <p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Frequent coughing <input type="checkbox"/> Spitting up blood <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Asthma or wheezing <p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> Glandular or hormone problem <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Excessive thirst or urination <input type="checkbox"/> Heat or cold intolerance <input type="checkbox"/> Dry skin <p>Genito-Urinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination <input type="checkbox"/> Slow stream <p>Neuro</p> <ul style="list-style-type: none"> <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness/tingle |
|--|---|---|--|

Medications: Please list all medications and supplements (medical, nutritional, and herbal) with dosage, if known:

Allergies: Please list allergies to any medications:

Family History: Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Check here if adopted or unknown.

Illness	Which family member(s)?	Approx. age when diagnosed
<input type="checkbox"/> Breast Cancer	_____	_____
<input type="checkbox"/> Gynecologic Cancer (ovarian, uterine, cervix)	_____	_____
<input type="checkbox"/> Other Cancer (i.e. – colon, melanoma, pancreatic)	_____	_____
<input type="checkbox"/> Heart Disease, Hypertension, High Cholesterol or Triglycerides	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Osteoporosis, Fractures	_____	_____
<input type="checkbox"/> Alzheimer's	_____	_____
<input type="checkbox"/> Blood Clots (Pulmonary embolism, DVT)	_____	_____

Social History

Marital Status: Single Married Divorced Widowed Separated If married, how long? _____

Are you a student? If so, where and what grade level? _____

Are you or have you ever been a smoker? Yes No If yes, how many per day? _____ How long? _____

Alcohol use? Yes No If yes, how much per week? _____

Drug use? Yes No If yes, what type and how often? _____

Have you ever been physically or sexually abused? Yes No

Are you currently being physically or sexually abused? Yes No

Questions: Do you have any particular concerns, special needs, questions, or comments? Please note them below.

The above information is true and correct to the best of my belief.

(SIGNATURE)

(DATE)