PERSONAL HEALTH HISTORY

Name: _____ Date Of Birth: _____

MEDICATIONS (List current medicines you are taking including dosages and how often taken include non-prescription drugs)
(If you have your medications with you, you may skip the Medication section and present them to the nurse)

_____

ALLERGIES (Check those that apply)

___Penicillin ___Sulfa ___Aspirin ___Latex ___Iodine ___None
___Other_____

PAST/CURRENT MEDICAL CONDITIONS (Check if you have had any of the following)

___Fibrocystic Disease of Breast	___Pain with Sexual Intercourse	___Heart Attack
___Breast Lump	___Sexually Transmitted Disease	___High Cholesterol
___Breast Discharge	___Urinary Problems	___Strokes/CVA
___Pelvic Pain	___Leakage of Urine	___Seizures or Epilepsy
___Pelvic Inflammatory Disease	___Vaginal/Rectal Prolapse	___Stomach or Duodenal Ulcers
___Endometriosis	___Rectal Bleeding	___Colitis or Bowel Disease
___Ovarian Cyst	___Anemia	___Liver Disease or Hepatitis
___Polycystic Ovarian Disease	___Blood Clots in Legs, Lungs, Etc.	___Gallbladder Stones or Disease
___Heavy Menstrual Periods	___Blood Clotting Disorders	___Lupus
___Irregular Menstrual Periods	___Obesity	___Chronic Headaches
___Absence of Menstrual Periods	___Diabetes	___Depression
___Postmenopausal Bleeding	___Thyroid Disease	___Psychiatric Disorder
___Abnormal Pap Smear	___High Blood Pressure	___Drug or Alcohol Abuse
___Infertility	___Cancer or Tumor (Location)_____	

___Other _____

SURGICAL HISTORY (Please check the surgeries you have had)

___Hysterectomy	___Mastectomy	___Gastric Bypass
___Breast Implants	___Removal of Ovary (Left, Right or Both)	___Hernia Repair
___Breast Reduction	___Anterior And Posterior Repair	___Angioplasty
___Diagnostic Laparoscopy	___Heart Bypass Surgery	___C-Section
___D&C	___Appendectomy	___Orthopedic Surgery
___TVT or TOT (Bladder Repair)	___Cholecystectomy (Gallbladder Removal)	___Tubal Ligation
___Tonsillectomy	___Other _____	

SOCIAL HISTORY (Check those that apply)

Marital Status: ___Single ___Married ___Divorced ___Widowed
Occupation _____
Do you exercise daily? ___Yes ___No
Do you have a Living Will? ___Yes ___No
Do you smoke cigarettes? ___Yes ___No If yes, # per day? ___ # of Years ____
Do you drink alcohol? ___Yes ___No If yes, # per day/week? ___/___ # of Years ____

Are you using any of the following recreational drugs? (Check those that apply)

___Suboxone ___Subutex ___Marijuana ___Oxycontin ___Cocaine
___Lortab ___Percocet ___Roxicodone ___MS Contin ___Methadone
___Other _____

IMMUNIZATIONS (Check the vaccinations you have received and date, if known)

( ) Flu Date: _____ ( ) Tetanus Date: _____ ( ) HPV Date: _____

Provider/Nurse Reviewed:_____ Chart #:_____

FAMILY HISTORY (Indicate the illnesses or cause of death in your immediate family members)

	Father	Mother	Brothers	Sisters	Children	Grandparents
Breast Cancer	_____	_____	_____	_____	_____	_____
Ovarian Cancer		_____		_____	_____	_____
Uterine Cancer		_____		_____	_____	_____
Cervical Cancer		_____		_____	_____	_____
Colon Cancer	_____	_____	_____	_____	_____	_____
Lung Cancer	_____	_____	_____	_____	_____	_____
Pancreatic Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
CVA/Stroke	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____	_____	_____
Hyperlipidemia	_____	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____	_____
Endometriosis		_____		_____	_____	_____
Blood Clotting Disorders	_____	_____	_____	_____	_____	_____
Free Bleeding Disorders	_____	_____	_____	_____	_____	_____
Other_____	_____	_____	_____	_____	_____	_____

SEXUAL HISTORY

Are you currently sexually active? ___Yes ___No

Current form of birth control: (Check those that apply)

___OCP's (oral contraceptive pills) ___Depo-Provera ___Condoms ___Implanon
___IUD ___Essure ___Tubal Ligation ___NuvaRing
___Adiana ___Vasectomy ___None ___Other _____

Age of onset of sexual activity: ___ less than age 16 ___ age 16 or greater
Number of sexual partners in your lifetime: ___ less than 5 ___ 5 or more

History of sexually transmitted diseases: (Check those that apply)

___HPV (Human Papilloma Virus) ___Chlamydia ___Gonorrhea ___Syphilis
___Condyloma (Genital Warts) ___ HIV ___PID (Pelvic Inflammatory Disease)

WOMEN'S HEALTH

How many times have you been pregnant? _____
Number of full-term births (including stillbirths) _____
Number of pre-term births _____
Number of miscarriages or abortions _____
Have you had a hysterectomy? ___Yes ___No If yes, Date: _____
Last menstrual period Date: _____
Last pap smear Date: _____ Result: _____
Last complete physical exam Date: _____
Last mammogram Date: _____ Result: _____
Do you perform monthly self-breast examinations? ___Yes ___No

Reason for your visit today: _____

Are there any concerns/issues that you would like to discuss today with the provider?

_____

_____

Provider/Nurse Reviewed:_____ Chart #:_____