

Confidential Health History



Name _____

Date of Birth _____ **Age** _____

Primary Physician _____

Date _____

Please list medications (<i>including herbals</i>) and dosage you are currently taking: _____ _____ _____ _____	Please list drug allergies and reaction (e.g. sulfa = rash): _____ _____ _____
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Past Medical History - Circle All That Apply:	Past Surgical History - Please note approximate year for applicable surgeries:
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Abnormal Uterine Bleeding Abnormal PAP Smear Fibroids Herpes / Other STD Infertility HIV or AIDS Breast Disease/Lumps GERD / Hiatal hernia Irritable Bowel Disease Colitis or Inflammatory Bowel Disease Hepatitis Stomach Ulcers Diabetes Thyroid Disorder	Anemia Arrhythmia Heart Disease High Blood Pressure High Cholesterol Asthma Tuberculosis Bladder Infection Incontinence Kidney Disease or Stone Anxiety Disorder Migraine Headaches Depression Cancer (type) _____ Other _____	Hysterectomy Laparoscopy Hysteroscopy Bladder Repair Appendectomy Cesarean Section Ovaries Removed Tubal Banding? Ligation Cervical Cone Biopsy Vaginal Wall Repair Gallbladder Removal Tonsillectomy/Adenoidectomy Other: _____ _____	Year _____ Year _____ Year _____ Year _____ Year _____ Year _____ Year _____ Year _____ Year _____ Year _____ Year _____ Year _____ Year _____ Year _____
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List any other health problems:

Reproductive History

<ul style="list-style-type: none"> ✓ Age at first menstrual period _____ ✓ Average number of days from the beginning of one cycle to the beginning of next cycle _____ ✓ Number of pregnancies _____ ✓ Number of live births _____ ✓ Number of miscarriages /abortions ____ / ____ 	<ul style="list-style-type: none"> ✓ Date of last menstrual period _____ / ____ / ____ ✓ Number of days your flow lasts _____ ✓ Any bleeding between cycles? Yes / No ✓ Are you currently sexually active? Yes / No ✓ Any bleeding after intercourse? Yes / No ✓ Birth control method: _____ ✓ Satisfied with current method? Yes / No ✓ Planning a pregnancy in the next year? Yes / No
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Reproductive History - continued					
Birth Mo/ Year	Sex	Birth Weight	Term or Preterm	Type of Delivery (Vaginal or C/S)	
Family History		Social History			
Please indicate any immediate family members who have any of the following: Diabetes _____ Heart Disease _____ High Blood Pressure _____ Kidney Disease _____ Thyroid Disease _____ Cancer (type) _____ Lung Disease _____ Inheritable Anemia / Blood Disorders _____ Depression/Mental Illness/Alzheimer's _____ Other: _____		As health care providers, we realize many people live in less than ideal situations, and it is our responsibility to offer help if you are in an unsafe environment. Please let us know if you do not feel safe in your current relationship or would like a referral to a mental health or legal professional. <input checked="" type="checkbox"/> Do you feel safe in your relationship? Yes / No <input checked="" type="checkbox"/> Are you being hurt in any way? Yes / No <input checked="" type="checkbox"/> Have you ever been forced to have sex against your will? Yes / No <input checked="" type="checkbox"/> Do you have anything you want to tell us that might influence your care? Yes / No _____			
Preventive Health Behaviors		Yes	No		
Do you? Smoke (if yes, how many / day _____) Drink alcohol (if yes, how many / week _____) Use recreational drugs Perform self-breast exams monthly Use sunscreen daily Have eye exams annually See a dentist every 6-12 months Use seatbelts consistently Exercise regularly		_____ _____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____ _____		
		Yes	No	N/A	Don't Know
<u>Vaccines current?</u> Tetanus Year of last one _____ Diphtheria Year of last one _____ Hepatitis Year of last one _____ Flu Year of last one _____		_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
<u>Ever had?</u> a mammogram Year of last one _____ a colonoscopy Year of last one _____ a cholesterol screening Year of last one _____ a bone mineral density Year of last one _____		_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____

