PATIENT HEALTH HISTORY

PLEASE COMPLETE BOTH PAGES

DATE:_____ FORMER PATIENT: YES OR NO IF YES, LAST DATE SEEN _____

PATIENT NAME:_____ DATE OF BIRTH_____

OCCUPATION_____ PROVIDER HOSPITAL _____

MARITAL STATUS_____

MEDICATION ALLERGIES: (include type of reaction) _____

_____

MEDICATIONS Prescription & Over the Counter:

_____

_____

PHARMACY (CITY, STREET & PHONE NUMBER) _____

_____

PAST MEDICAL HISTORY:_____

_____

GYNE HISTORY:

HYSTERECTOMY: YES OR NO *IF YES YOU MAY SKIP TO THE NEXT SECTION

AGE PERIODS BEGAN _____FIRST DAY OF LAST MENSTRUAL PERIOD_____

LENGTH OF CYCLES (1st day of period to 1st day of next period) _____

USUAL LENGTH OF PERIOD _____days FLOW: LIGHT MODERATE HEAVY (circle one)

PAINFUL PERIODS: YES OR NO IF YES: MILD MODERATE SEVERE

Have you ever been Sexually Active: (circle one) YES NO

METHOD OF BIRTH CONTROL : (circle one) ABSTINENCE PILLS NUVARING CONDOMS IUD

TUBAL LIGATION DEPO PROVERA PARTNER VASECTOMY NONE OTHER_____

IF MENOPAUSAL PLEASE INDICATE AT WHAT AGE PERIODS SUBSIDED_____

URINARY HISTORY:

DO YOU EXPERIENCE URINARY INCONTINENCE? YES OR NO IF YES: STRESS URGE OR BOTH

IF YOU HAVE INCONTINENCE DO YOU CURRENTLY PERFORMING KAGEL EXERCISES? YES OR NO

OBSTETRIC HISTORY:

TOTAL NUMBER OF PREGNANCIES _____# FULLTERM DELIVERIES_____(Vaginal or C/S)

PRETERM DELIVERIES_____ ABORTIONS _____MISCARRIAGES_____ ECTOPIC _____

Living _____

SOCIAL HISTORY:

SMOKING: YES OR NO OR FORMER IF YES INDICATE # PER DAY: _____ # YEARS: _____

ALCOHOL USE: YES OR NO OR FORMER IF YES INDICATE: OCCASIONAL MODERATE HEAVY

DRUG USE: YES OR NO IF YES INDICATE KIND OF DRUGS USED _____

EXERCISE REGULARLY: YES OR NO IF YES WHAT KIND AND HOW OFTEN _____

FAMILY HISTORY: PLEASE INDICATE FAMILY MEMBER (EX. MOTHER, MATERNAL GRANDMOTHER ETC.)

CANCER _____ DIABETES _____

HEART DISEASE _____ HYPERTENSION _____

STROKE _____ OTHER _____

HEALTH SCREEN / IMMUNIZATIONS: **LIST DATE AND RESULTS **

PAP SMEAR _____ HISTORY OF ABNORMAL PAP SMEAR: YES OR NO

*IF YES PLEASE LIST ABNORMAL PAP TREATMENTS: _____

MAMMOGRAM _____ INFLUENZA VACCINE _____

PHYSICAL EXAM _____ COLONOSCOPY _____

CHOLESTEROL SCREEN _____ OTHER _____

SURGERIES: (PLEASE LIST ALL AND DATES)

_____

_____

FAMILY MD (ADDRESS & PHONE) _____