Name:_____ Date of Birth:_____ Age: _____

Health History

Please fill in the blanks and circle the option in italics that applies to you.

Reason for your visit:_____

How did you hear about us?_____

Do you have any known allergies to medications, latex, or food? *Yes No*

Allergy:_____ Reaction:_____ Date of first reaction:_____

Allergy:_____ Reaction:_____ Date of first reaction:_____

Allergy:_____ Reaction:_____ Date of first reaction:_____

Allergy:_____ Reaction:_____ Date of first reaction:_____

Are you taking any prescribed medications, over the counter medications, vitamins, or supplements? *Yes No*

Name:_____ Dosage:_____ Frequency:_____

Name:_____ Dosage:_____ Frequency:_____

Name:_____ Dosage:_____ Frequency:_____

Name:_____ Dosage:_____ Frequency:_____

Name:_____ Dosage:_____ Frequency:_____

Personal Health History

Please circle any problems you have been diagnosed with or are taking medications to treat.

Acid Reflux
Acne
Anemia
Anesthesia Complications
Anxiety Disorder
Arthritis
Asthma
Autoimmune Disorder
Birth Defects
Bladder Problems
Blood Clots
Blood Disorders
Blood Transfusions
Breast Cancer
Breast Problems
Cancer: Type_____
Depression
Diabetes Type 1
Diabetes Type 2
Eating Disorders
Eczema
Endometriosis
Fibromyalgia
GI Problems
Headache Migraines
Heart Disease
Heart Problems
Hepatitis
High Cholesterol
High Blood Pressure
Infertility
Inherited Disease
Kidney Problems
Kidney Disease
Liver Disease
Lung Disease
Osteoporosis
Ovarian Cancer
Polycystic Ovaries
Polyps
Preeclampsia
Psychiatric Condition
Seizures
Skin Disorders
Stroke
Thrombophilia
Thyroid Problems
Uterine Anomaly
Varicosities

GYN History

Age of first period:_____

Duration of period:_____

1st day of your most recent period:_____

Approximate Definite Unknown

Days between cycle:_____

Flow: *Heavy Medium Light*

Cramps: *Mild Moderate Severe*

Bleeding between periods: *Yes No*

Sexually active: *Yes No*

Bleeding after intercourse: *Yes No*

Pain with intercourse: *Yes No*

Date of last pap smear:_____

Results: *Normal Abnormal*

History of abnormal paps: *Yes No*

Date of abnormal:_____

Current birth control method:_____

Desired method of birth control:_____

HPV Vaccine completed: *Yes No*

History of STDs/STIs: *Yes No*

If yes, please list:_____

Date of last mammogram:_____

Results: *Normal Abnormal*

If post menopausal, age at menopause:_____

On hormone replacement therapy: *Yes No*

Date of last colonoscopy:_____

Results: *Normal Abnormal*

Name:_____ Date of Birth:_____ Age: _____

Past Pregnancies

Number of pregnancies:_____ Number of miscarriages:_____
Number of full term deliveries:_____ Number of abortions:_____
Number of premature deliveries:_____ Number of live births:_____

Ectopics, Abortions, and Miscarriages:
Ectopic Miscarriage Abortion Date:_____ Required surgery: *Yes No*
Ectopic Miscarriage Abortion Date:_____ Required surgery: *Yes No*
Ectopic Miscarriage Abortion Date:_____ Required surgery: *Yes No*
Ectopic Miscarriage Abortion Date:_____ Required surgery: *Yes No*

Deliveries:

Date	Length of Pregnancy	Length of Labor	Cesarean or Vaginal	Anesthesia If so, what type?	Birth Weight	Sex	Complications (Heavy bleeding, vaginal tears, forceps, preeclampsia etc.)

Family Health History

Please list any chronic medical conditions in your family (like cancer, diabetes, high blood pressure, etc.), who the person is, and if they are on your maternal or paternal side of the family.

Disease:_____Family Member:_____ Age of Onset:____ *Living Deceased*
Disease:_____Family Member:_____ Age of Onset:____ *Living Deceased*
Disease:_____Family Member:_____ Age of Onset:____ *Living Deceased*
Disease:_____Family Member:_____ Age of Onset:____ *Living Deceased*
Disease:_____Family Member:_____ Age of Onset:____ *Living Deceased*
Disease:_____Family Member:_____ Age of Onset:____ *Living Deceased*

Social History

Tobacco use: *Never Current Former*
Packs per day/week:_____
Years of use:_____
If former, date you quit:_____
Smokeless tobacco: *Never Current Former*
If yes: *Chew Snuff*
E-Cig/Vape use: *Never Former Current*
Occupation:_____
Highest level of education:_____
Current student: *Yes No*
School name:_____
Marital Status:_____
You live: *Alone With others*
Currently employed: *Yes No*

Alcohol use: *Yes No*
Number of drinks per *day/week*:_____
Max number of drinks at one time:_____
Caffeine Intake: *Yes No*
Number of drinks per *day/week*:_____
Recreational drug use: *Yes No*
Type:_____
I prefer to have sex with: *Men Women Both*
# of sexual partners in the last year:_____
Protected sex: *Always Usually No*
You perform monthly self-breast exams: *Yes No*
You always wear your seat belt: *Yes No*
Exercise Level:
None Occasional Moderate Heavy

Name:_____ Date of Birth:_____ Age: _____

Dietary Restrictions: *Yes No*
If so, what kind:_____
You are afraid of your partner: *Yes No*
Someone close to you has threatened to hurt you:
Yes, recently
In the past, but no longer a concern
No

Someone has forced you to have sex:
Yes, recently
In the past, but no longer a concern
No
Someone has hurt you physically:
Yes, recently
In the past, but no longer a concern
No

Surgical History

Please circle all that apply and write the date of the surgery

Abdominoplasty	Ectopic Pregnancy	Oophorectomy
Appendectomy	Endometrial Ablation	Oral Surgery
Breast Biopsy	Endometrial Biopsy	Orthopedic Surgery
Breast Implants	Gallbladder Removal	Ovarian Cystectomy
Other Breast Surgery	Hysterectomy	Thyroid Surgery
Cesarean Section	LEEP	Tonsillectomy
Colonoscopy	Laparoscopy	Tubal Ligation
Colposcopy	Laparotomy	Wisdom Teeth Removal
Cryotherapy	Mastectomy	
Dilation and Curettage	Myomectomy	

Other:_____
_____

Pregnancy Related Social History

Please complete if you are currently pregnant

A blood transfusion is acceptable in an emergency: *Yes No*
You have consumed alcohol or marijuana since your last period: *Yes No*
You have used illicit drugs since your last period: *Yes No*
Name of spouse/father of the baby:_____ Phone Number:_____

Staff Use Only:

H: W: BP: T:
Pharmacy:
Notes: