PATIENT HEALTH HISTORY

PLEASE COMPLETE BOTH SIDES

DATE:_____

PATIENT NAME:_____ DATE OF BIRTH_____

OCCUPATION_____ PROVIDER HOSPITAL _____

MEDICATION ALLERGIES: (include type of reaction) _____

_____

MEDICATIONS: _____

_____

LOCAL/MAIL ORDER 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

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 _____NO. FULLTERM DELIVERIES_____(Vaginal or C/S)

NO. PRETERM DELIVERIES_____ ABORTIONS _____MISCARRIAGES_____ ECTOPIC _____

SOCIAL HISTORY:

SMOKING: YES OR NO IF YES INDICATE NO. PER DAY: _____ NO. YEARS: _____

ALCOHOL USE: YES OR NO 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_____ HEPATITIS B VACCINE_____

CHOLESTEROL SCREEN_____ COLONOSCOPY_____

BLOOD SUGAR SCREEN_____ OTHER_____

SURGERIES: (PLEASE LIST ALL AND DATES)

_____

_____

FAMILY MD (ADDRESS & PHONE)_____

********NURSE USE ONLY******** **HT:** _____ **WT:**_____ **BP:**_____