**Women's Healthcare Associates of Santa Monica**

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## Health History:

**Last Name:_____First Name:_____ MI:____ Date:_____**
**DOB:_____ Age:_____ Primary Care Physician:_____**
**Emergency Contact:_____ Relationship:_____ Phone#:_____**

**Past Medical/Surgical History: (**i.e. Endometriosis, Ovarian Cyst, Hospitalizations, Surgeries, etc.)

| Illness | Year | Illness | Year |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Family History: (**Please list serious illnesses in your immediate family)

| Illness | | Illness | |
|---|---|---|---|
| Heart Disease/Heart Attack | Y N | | Y N |
| Diabetes | Y N | | Y N |
| Cancer | Y N | | Y N |
| | Y N | | Y N |

**Social History:** (If Appropriate)

| |
|---|
| Do you drink alcohol? Y N If so, how much? |
| Do you or someone in your household smoke? Y N If so, how much? |
| Living Arrangements: Husband Children Other |
| Education Level: HS College Grad School |

**Please check if you have recently experienced any of the following:**

| **General** | **Respiratory** | **GI** | **Skin/Breast** |
|---|---|---|---|
| ☐ Trouble sleeping | ☐ Cough | ☐ Nausea | ☐ Rash |
| ☐ Always tired | ☐ Shortness of breath | ☐ Vomiting/dry heaves | ☐ Lesions/moles |
| ☐ Loss of appetite | ☐ Breathing discomfort | ☐ Heartburn | ☐ Recurrent boils |
| ☐ Weight loss | ☐ Wheezing | ☐ Bloating | ☐ Discoloring |
| ☐ Weight gain | ☐ Snoring | ☐ Constipation | ☐ Irregular growth |
| ☐ Recurrent infection | ☐ Sleep apnea | ☐ Diarrhea | ☐ Itching |
| ☐ Excessive thirst | | ☐ Loose stools | ☐ Breast pain |
| ☐ Fever | **CVS** | ☐ Black/bloody stools | ☐ Discharge from nipples |
| ☐ Chills | ☐ Chest pain | ☐ Rectal bleeding | ☐ Breast lumps |
| ☐ Night sweats | ☐ Palpitations | ☐ Abdominal pain | |
| ☐ Hot flashes | ☐ Discomfort in chest | | **Neurological** |
| | ☐ Calf/leg pain | **GU** | ☐ Blackouts |
| **HEENT** | ☐ Ankle swelling | ☐ Excessive urination | ☐ Headache |
| ☐ Hay fever | | ☐ Urinary urgency | ☐ Dizziness |
| ☐ Sinus pain | **Musculoskeletal/Extremities** | ☐ Pain with urination | ☐ Poor balance |
| ☐ Blurred vision | ☐ Swollen joints | ☐ Difficulty with urination | ☐ Memory loss |
| ☐ Eye pain | ☐ Stiffness in muscles | ☐ Blood in urine | ☐ Tremors |
| ☐ Red eyes | ☐ Stiffness in joints | ☐ Waking to urinate | ☐ Visual disturbances |
| ☐ Watery eyes | ☐ Muscle aches | ☐ Weak stream | ☐ Tingling/numbness |
| ☐ Itchy eyes | ☐ Stiff neck | ☐ Pelvic pain | ☐ Paralysis |
| ☐ Hearing loss | ☐ Back pain | ☐ Irregular periods | ☐ Weakness in hands/feet |
| ☐ Ear pain | ☐ Neck pain | ☐ Vaginal yeast infections | |
| ☐ Ear drainage | | | **Psychiatric** |
| ☐ Ringing in ears | **Lymphatic/Heme** | Last Pap: | ☐ Anxiety |
| ☐ Runny nose | ☐ Swollen glands | Last Period: | ☐ Fear |
| ☐ Congested nose | ☐ Easy bruising | # of Pregnancies: | ☐ Depression |
| ☐ Hoarseness | ☐ Free bleeder | # of Live births: | ☐ Change in behavior |
| ☐ Swallowing pain | | | ☐ Loss of interest in hobby |
| ☐ Sore throat | **Other:** | **Other:** | ☐ Difficulty concentrating |