HEALTH HISTORY SHEET

Welcome to Palo Alto Women's Health Center! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Last Name:	First:	Age:	Sex:	Doctor Notes *please do not write in this **area***
Presenting Problem or Proposed Surgery:				

Have you or any blood relative had:

	Yes	No	Who	Year
Allergies, asthma, hay fever				
Anemia				
Alcoholism				
Arthritis				
Bleeding problems				
Birth defects				
Cancer				
Emphysema				
Epilepsy or seizures				
Heart Trouble				
Mental illness				
Migraine headaches				
Rheumatic fever				
Stroke				
Suicide				
Thyroid disease/goiter				
Tuberculosis				
Ulcers				
Venereal disease				
Osteoporosis				
Glaucoma				
Gallstones				

Names of Other Present MDs	Last Visit	Childhood Immunizations	Year
		Tetanus	
		Childhood Diphtheria	
		Childhood Polio	
		Pneumovax	
		Flu Shot	
		Last TB Test	
		TB: ☐ Positive	☐ Negative

ALLERGIES: Please list type and reaction ☐ NONE

Name of Drug/Item	Reaction	Name of Drug/Item	Reaction

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Patient Name: ____

MEDICATIONS						Doctor Notes *do not write in this area*
Have you EVER TAKEN:	Yes	No	Year	How Long?	Brand/Descr/Dose	
Blood pressure pills						
Cortisone/steroids						
Diet pills						
Diabetes pills						
Thyroid pills						
Tranquilizers						
Water pills						
Are you NOW taking:						
Antacids						
Aspirin						
Antibiotics						
Birth control pills						
Blood thinner pills						
Laxatives						
Pain pills						
Sleeping pills						
Vitamins						
OTHER *Please list*						

OB/GYN HISTORY	Date or no. if requested	Yes	No
Date of last menstrual period:			
Are your menses irregular?			
No. of days between periods			
No. of days periods last			
Spotting between periods?			
Do you forget to do self breast exams monthly?			
Are you pregnant			
No. of pregnancies			
Date of last pregnancy			
No. of live births			
No. of abortions or miscarriages			
Date of last Pap smear			
Was it abnormal?			
Have you ever had any other abnormal Pap?			
Are you currently using contraception?			
Type of contraception			
Types of contraceptives used in past			
Did your mother take DES during her pregnancy?			
Over 1 year since last mammogram? If yes, date:			

SURGICAL HISTORY: Name of Operation	Date	Complications

Have you ever had bleeding problems? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No Date:__________

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MAJOR ILLNESS OR INJURY: list any illness or injury requiring hospitalization, prolonged care, or use of medication. Include approximate date. ________________ ____ ____	

HEALTH HISTORY SHEET

Patient Name: ____

PERSONAL HABITS/RISK FACTORS				Doctor Notes *please do not write in this area*
	Yes	No	Answers	
Do you smoke or chew tobacco?			No. packs/day:	
Have you ever smoked in the past?			Date started:	
			Date stopped:	
Do you often miss 3 meals/day?				
Do you eat snacks regularly?				
Do you have an eating problem?				
Any diet preferences/restrictions?				
Type				
Dietary habits			Frequency or No.:	
☐ Low fat				
No. servings/day vegetables/fruits				
No. servings/day grains				
No. times/week you eat red meat				
No. servings/day dairy				
No. caffeine drinks/day				
Ave. alcoholic drinks/day				
No. times "drunk"/year				
Ever had a drinking problem?				
Ever had a drug problem?				
Every used intravenous drugs?			Date last used:	
Do you ever not use seat belts?				
No. hours sleep/day				
Highest grade level achieved				
Do you not know how to swim?				
Do you not exercise regularly?				
What exercise do you do?				
How often/week?			Duration:	
What do you do to relieve stress?				
Any pets?				
Any hobbies?				
Occupation:				
Do you hate your job?				
Is your job a risk to your health?				
If yes (in any way), please explain:				

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<table>
<tr><td colspan="3">SOCIAL HISTORY
Are you: ☐ Married
☐ Divorced ☐ Single
☐ Widowed ☐ Living with “signif. other”</td><td>Do you have children?
☐ Yes ☐ No
If yes, please list No. & age(s)</td><td rowspan="4">If there are any special concerns you would like to discuss with the doctor, please continue on the reverse of this sheet. Thank you for providing us with this important information.</td></tr>
<tr><td>SEXUAL HISTORY</td><td>Yes</td><td>No</td><td rowspan="3">Sexual partners in past year:
No. men
No. women
No. unprotected</td></tr>
<tr><td>Are you sexually active?</td><td></td><td></td></tr>
<tr><td>Is sex unsatisfactory in any way?</td><td></td><td></td></tr>
<tr><td>History of Chlamydia?</td><td></td><td></td><td rowspan="4">AIDS, cont’d
Would you like to have a test?
☐ Yes ☐ No</td><td></td></tr>
<tr><td>Gonorrhea?</td><td></td><td></td><td></td></tr>
<tr><td>Venereal warts?</td><td></td><td></td><td></td></tr>
<tr><td>Are you concerned about AIDS?</td><td></td><td></td><td></td></tr>
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