# Health History

**Patient Name:** ____________________________________________ **Date of Birth:** ______________________

**Reason for visit:** ________________________________________________________________________________

**Medications/Herbals or Vitamins:** (name, dosage and directions-feel free to attach a separate list)

_______________________________________ ________________________________________

_______________________________________ ________________________________________

_______________________________________ ________________________________________

**Allergies: Medication/Environmental/Food** (If **Yes**, please specify medication and reaction)

________________________ _______________________ _______________________

________________________ _______________________ _______________________

**Medical History:** (please circle Yes or No)

| | | | |
|---|---|---|---|
| Asthma | Yes / No | Hypertension | Yes / No |
| Bleeding/Clotting Disorder | Yes / No | High Cholesterol | Yes / No |
| Cancer | Yes / No | Autoimmune Disorder | Yes / No |
| Psychological Disorder | Yes / No | Stroke | Yes / No |
| Tuberculosis | Yes / No | Osteopenia/Osteoporosis | Yes / No |
| Neurological Disorder | Yes / No | Heart Disease/Attack | Yes / No |
| Lung Disease | Yes / No | Thyroid Disorder | Yes / No |
| Hepatitis/Liver Disease | Yes / No | Date of last Colonoscopy: ____________________________ | |

If you answered yes to any of the above questions, please explain. Include date, treatment received and if available, physician treating the condition:

______________________________________________________________________________________________

______________________________________________________________________________________________

Have you had a blood transfusion? Yes or No If yes: When? ___________________________________



Rev. 3/19

## GYN History

| | |
|---|---|
| Date of last pap: Normal or Abnormal | Length of periods (days): |
| HPV vaccine: Yes or No | Number of days between periods: |
| History of Abnormal Pap Smears: Yes or No | Sexually active: Yes or No |
| Date of last mammogram: Normal or Abnormal | Your partner(s): Male/Female/Both |
| Date of bone density: Normal or Abnormal | Birth control method: |
| Age of 1st period: | Age at onset of menopause: |
| Last menstrual period: | History of STDs: |

## Pregnancy History

# of pregnancies: ________ # of miscarriages: ________ # of abortions: ________
How many c-sections: ________ How many living children: ________

**Surgical History:** (what type of surgery and when)

________________________________________ ________________________________________

________________________________________ ________________________________________

**Hospitalizations:** (which hospital, when and the reason for admission/ER visit)

________________________________________ ________________________________________

________________________________________ ________________________________________

**If over 65, have you fallen in the past year? If so, what caused the fall(s) (such as dizziness, related to medication, low blood sugar, tripped, etc.)?**

________________________________________________________________________________

________________________________________________________________________________

**Family History:**

| | Breast Cancer | Ovarian Cancer | Uterine Cancer | Colon Cancer | Osteoporosis | Pancreatic Cancer | Other |
|---|---|---|---|---|---|---|---|
| All Family | | | | | | | |



Rev. 3/19

**Social History:**

Caffeine (drinks or caffeine containing drugs) Yes / No If Yes: How Much? _______________

Tobacco Yes / No If Yes: How much per day? ___________ How long used? _____________

Alcohol Yes / No If Yes: How much per day? ___________ How long used? _____________

Drug Use (illicit or non-prescribed) Yes / No If Yes: How often? _______ What type? __________

Domestic Abuse Yes / No If yes: Past or Present

**Specialists:** (name of physician and condition treated)

__________________________________ ______________________________________

__________________________________ ______________________________________

**Patient (or Responsible Party) Signature: _____________________________________________**

**Date: ______________________________**



Rev. 3/19