Confidential Patient History

Name: _____ Date: _____

Social Security #: _____ Date of Birth: _____ Marital Status: S M Sep W D

Primary Care Provider: _____ Phone: _____

Are you allergic to: **Copper** ☐☐ **Rubber/Latex** ☐☐ **Iodine or Shellfish** ☐☐

Date of last tetanus shot (month/year) _____

Allergies to medications: Please list name of drug & reaction

_____

_____

Family History

Has anyone in your family had the following: Include Mother (M), Father (F), Brother (B), Sister (S) Grandfather (MGF or PGF – Maternal or Paternal), or Grandmother (MGM or MGF – Maternal or Paternal).

No Yes Who		No Yes Who		No Yes Who	
☐☐	_____ Diabetes	☐☐	_____ High Blood Pressure	☐☐	_____ Sickle Cell Disease
☐☐	_____ Heart Attack	☐☐	_____ Stroke	☐☐	_____ Birth Defects/Hereditary Disease
☐☐	_____ Colon Cancer	☐☐	_____ Breast Cancer	☐☐	_____ Uterine Cancer
☐☐	_____ Tuberculosis	☐☐	_____ Thyroid Disease	☐☐	_____ Ovarian Cancer
				☐☐	_____ Other _____

Parents and Siblings are alive and well? Yes No

If deceased please list:

Age	Relation	Cause of Death

Age	Relation	Cause of Death

Medical History/Review of Systems: Do you have, or have you ever had, any of the following:

No Yes		No Yes		No Yes	
☐☐	Anemia	☐☐	Cancer	☐☐	Kidney Problem
☐☐	Sickle Cell Trait or Disease	☐☐	Breast Disease	☐☐	Bladder Infection
☐☐	Sickle Cell Test	☐☐	Diabetes	☐☐	Stomach/Bowel Problem
☐☐	Rheumatic Fever	☐☐	Thyroid Problem	☐☐	Liver Disease
☐☐	Heart Disease	☐☐	Severe Depression/Anxiety	☐☐	Hepatitis
☐☐	Heart Murmur	☐☐	Blood Transfusion	☐☐	Mononucleosis
☐☐	Do you take antibiotics for dental work?	☐☐	Numbness or Tingling of Extremities	☐☐	Jaundice
				☐☐	Contact Lenses
☐☐	High Blood Pressure	☐☐	Epilepsy/Seizures	☐☐	Asthma
☐☐	Varicose Veins, Blood Clots, Phlebitis, or bleeding disorder	☐☐	Stroke	☐☐	Gall Bladder Problem
		☐☐	Frequent Headaches	☐☐	Chicken Pox
☐☐	High cholesterol	☐☐	Migraine Headaches	☐☐	Other Illness (please list)
☐☐	Chronic Sinus Problems	☐☐	Rubella Infection or Immunization (German Measles)		_____
☐☐	Tuberculosis Test				_____
☐☐	HIV Exposure				

Surgical/Hospitalization History (Please list the date and type of surgery or reason for hospitalization)

Date	**Type**	**Date**	**Type**
_____		_____	
_____		_____	
_____		_____	

Current Medications (Including hormones, vitamins, herbs, non-prescription medications)

Drug Name	Dosage	Who Prescribed	Drug Name	Dosage	Who Prescribed

Menstrual History

Age period started _____ Date of last period _____
Periods come every ____ days and last for ___ days Periods are ☐ regular ☐ irregular ☐ light ☐ moderate ☐ heavy
Do you have cramps with your period? ☐ No ☐ Yes If Yes, what do you do for the discomfort _____
Do you bleed between periods? ☐ No ☐ Yes Do you feel as though your periods impact your quality of life? ☐ No ☐ Yes
Does your bleeding soak through one or more pads or tampons every hour for several hours? ☐ No ☐ Yes
Would you like information on a simple, safe procedure performed in our office that can significantly reduce or eliminate your monthly periods? ☐ No ☐ Yes

Gynecological History

Date of last Pap Smear:_____ Date of Last Mammogram:_____ Date of last DEXA Scan: _____

No Yes Now
☐☐☐ Vaginal Discharge/Infection
☐☐☐ Unusual Vaginal Bleeding
☐☐☐ DES exposure (did your mother take DES?)
☐☐☐ STD (Sexually Transmitted Disease)
☐ Syphilis ☐ Gonorrhea ☐ Trichomonas
☐ Chlamydia ☐ Herpes ☐ Genital Warts ☐ HIV

No Yes Now
☐☐☐ Abnormalities of the Uterus
☐☐☐ Tumors/Cysts of Ovaries
☐☐☐ Pain/Bleeding with intercourse
☐☐☐ Abnormal Pap Smear (Year) _____
☐☐☐ Cervical Lesions/Biopsy/Cryotherapy/Leep Cone
☐☐☐ Premenstrual Symptoms (mood changes, water retention, headaches, etc.)

Pregnancy History

Age of First Pregnancy:_____ ☐ Never been pregnant Have you ever had difficulty becoming pregnant? ☐ No ☐ Yes
List number of: Pregnancies _____ Living children _____ Abortions _____ Miscarriages _____
Children: List below

Name	Date of Birth	Sex	Birth Weight	Type of Delivery/Complications

Contraception

Age of first intercourse: _____ Are you sexually active at present?_____
If you have ever used birth control, please list all methods used in the past:

Birth Control Method	Date(s) of use	Any problems with this method (yes/no)

Present Method: _____ Used Since _____ Any problems? _____
When are you planning to have another child? (Please check one)
___ Within the next year ___ Within the next 5 years ___ Within the next 10 years ___ My family is complete
Would you like information on a non-surgical, hormone-free permanent birth control procedure performed in the comfort of our office? ____Yes ____No
Do you currently have a female partner? ☐ No ☐ Yes

Social/Personal History

Circle the highest year of school completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 > 17 Degree: _____
Occupation: _____ Employer: _____
Present weight is: ☐ Satisfactory ☐ Unsatisfactory Present weight is: ☐ About the same as a year ago ☐ more ☐ less
Caffeine: Average # cups per day: coffee _____ tea _____ caffeinated soda _____
Tobacco Use: ☐ Never ☐ Quit (when)_____ ☐ Currently Smoke _____ packs/day for _____ years
Recreational Drug Use: ☐ No ☐ Yes What? _____
Alcohol Use:
Have you ever felt the need to cut down on drinking? ☐ No ☐ Yes
Have you ever had guilty feelings about your drinking? ☐ No ☐ Yes
Do you ever take a drink first thing in the morning to steady your nerves or get rid of a hangover? ☐ No ☐ Yes
How many drinks does it take to feel an effect?_____ Has anyone ever told you that you drink too much? ☐ No ☐ Yes
What do you do for exercise? Type/Frequency: _____
Have you ever been physically, sexually or emotionally abused? ☐ No ☐ Yes
Do you perform monthly breast self exams (BSE)? ☐ No ☐ Yes
Are you interested in HIV/AIDS testing? ☐ No ☐ Yes
Sex: What questions do you have? _____
What concerns do you have to discuss with your health provider? _____

Reviewed: (please initial and date)