

Patient History Form

NAME _____ DATE ____ / ____ / ____

Patient ID# _____ D.O.B. ____ / ____ / ____ Age _____

A. REVIEW OF SYSTEMS:		
YES	NO	GENERAL
		1. Is your health generally good?
		2. Unexplained weight loss or gain of more than 10 lbs. in the past year?
		3. Night sweats/ hot flashes?
		4. Cancer? If yes, where / when?
		5. Tobacco use? If yes, for how many years? _____ If yes, <input type="checkbox"/> smoking? How many/day? _____ <input type="checkbox"/> chewing tobacco?
		6. Alcohol use? If yes, how many drinks/week?
		7. Are you being treated for any illness/condition now? If yes, what?
		8. Do you currently take medicine: prescription, over-the-counter, or herbal? If yes, what? Do you take any folic, vitamin, or nutritional acid supplements?
		9. Birth defects or genetic problems?
		10. Eye problems (except glasses or contacts)?
		11. Hearing problems?
		12. Frequent nosebleeds?
		13. Frequent sore throat?
CARDIO-RESPIRATORY		
		14. Mitral valve prolapse?
		15. Heart murmur?
		16. Varicose veins?
		17. Blood clots (head / leg / lungs)?
		18. Stroke or stroke-like problems?
		19. High blood pressure?
		20. High cholesterol?
		21. Chronic cough or other breathing problems / asthma?
		22. Tuberculosis or exposure to tuberculosis?
GASTROINTESTINAL		
		23. Stomach or bowel problems?
		24. Liver problems (hepatitis or tumor, etc.)?
		25. Gallbladder problems?
GENITOURINARY		
		26. Bladder, urine leaks, or kidney problems?
		27. Uterine fibroids?
		28. Ovarian cysts?
		29. Breast lump or nipple discharge?
		30. Vaginal discharge that itches, burns, or has a bad odor?
		31. Endometriosis?
		32. Pain with sex? Other sex problems?
		33. Previous abnormal pap result? When?
		34. Did your mother take DES to prevent a miscarriage when she was pregnant with you?
		35. History of sexually transmitted infection? If yes, check type: <input type="checkbox"/> Chlamydia? <input type="checkbox"/> Gonorrhea? <input type="checkbox"/> Genital warts? <input type="checkbox"/> Herpes? <input type="checkbox"/> Syphilis? <input type="checkbox"/> PID? <input type="checkbox"/> HIV/AIDS?
MUSCULOSKELETAL		
		36. <input type="checkbox"/> Arthritis? <input type="checkbox"/> Osteoporosis? <input type="checkbox"/> Other?
SKIN		
		37. Acne or other skin problems? If yes, what? _____ <input type="checkbox"/> Tattoo? <input type="checkbox"/> Piercing? If yes, where? _____
NEUROLOGICAL		
		38. Migraine headaches /Aura (diagnosed by MD / NP / PA)?
		39. Seizures / epilepsy?
		40. Numbness in arms / legs (recurring)?
PSYCHOLOGICAL		
		41. Depression requiring treatment? Have you ever considered suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No Other psychological problems?

A. (cont'd) REVIEW OF SYSTEMS:			
YES	NO	ENDOCRINE	
		42. Thyroid problems?	
		43. Diabetes?	
HEMATOLOGICAL/LYMPHATIC			
		44. Anemia (Low Iron)?	
		45. Sickle cell disease / trait?	
		46. Blood clotting disorder?	
ALLERGY			
		47. Are you allergic to any drug, medication, latex, or other substance, including local anesthesia? If yes, to what? Type of reaction: _____	
IMMUNIZATION (Check the ones you have received)			
		48. <input type="checkbox"/> Diphtheria?	
		49. <input type="checkbox"/> Hepatitis A?	
		50. <input type="checkbox"/> Hepatitis B? <input type="checkbox"/> shot 1? <input type="checkbox"/> shot 2? <input type="checkbox"/> shot 3?	
		51. Human Papillomavirus (HPV)? <input type="checkbox"/> shot 1? <input type="checkbox"/> shot 2? <input type="checkbox"/> shot 3?	
		52. <input type="checkbox"/> Measles/Mumps/Rubella (MMR)?	
		53. <input type="checkbox"/> Meningococcal?	
		54. <input type="checkbox"/> Pneumococcal?	
		55. <input type="checkbox"/> Tetanus?	
		56. <input type="checkbox"/> Varicella (chicken pox)?	
		57. <input type="checkbox"/> Other?	
B. HOSPITALIZATION AND SURGERIES			
Year	Reason		
C. FAMILY HISTORY			
		Are you adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Have your biological family (parents, brothers, sisters) had any of the following?	
YES	NO	Diagnosis	Relative
		Osteoporosis?	
		Diabetes?	
		Heart disease / heart attack / stroke before age 50??	
		High blood cholesterol?	
		Genetic problems?	
		Cancer? If yes, please specify _____	
		Blood clots?	
		Other?	
ADDITIONAL COMMENTS / EXPLANATIONS (by number)			

PLEASE COMPLETE OTHER SIDE

Patient History Form

NAME _____

DATE ____ / ____ / ____

D. PREGNANCY HISTORY: never pregnant

DELIVERED ABORTION / MISCARRIAGE

Mo.	Yr.	Vag.	C-Sec.	Birth Weight	Year	Weeks	Spont.	Induced

E. CONTRACEPTIVE HISTORY:

Current birth control method? _____ How long used? _____

Any problems with this method? Yes No

If yes, what? _____

What method do you want to use now? _____

Total number of children desired? _____

Are you planning a pregnancy in the NEXT year? Yes No

If not, what would you do if you become pregnant within the NEXT year? _____

Which of the following methods have you used in the past?

METHOD	COMMENT/PROBLEM
<input type="checkbox"/> Abstinence?	
<input type="checkbox"/> Tubal? <input type="checkbox"/> Vasectomy? <input type="checkbox"/> Hystorectomy?	
<input type="checkbox"/> Birth Control Pill?	
<input type="checkbox"/> The Patch?	
<input type="checkbox"/> The Ring?	
Implant: <input type="checkbox"/> Norplant? <input type="checkbox"/> Implanon?	
<input type="checkbox"/> Depo-Provera (The Shot)?	
<input type="checkbox"/> IUD?	
<input type="checkbox"/> Condoms?	
<input type="checkbox"/> Diaphragm? <input type="checkbox"/> FemCap? <input type="checkbox"/> Lea's Shield?	
<input type="checkbox"/> Sponge? <input type="checkbox"/> Spermicide?	
<input type="checkbox"/> Rhythm?	
<input type="checkbox"/> NFP (Natural Family Plan)?	
<input type="checkbox"/> Withdrawal?	

F. SOCIAL HISTORY

Emotional? Relationship problems?

Death of: Family member? Friend?

Job loss? Financial problems?

Problems in: Living arrangements? School?

Legal problems? Arrests? Divorce?

Do you have any parental problems? _____

Are you physically abused? _____

Has anyone forced you to have sex? _____

Are you sexually abused? _____

Are you afraid of your: Partner? Family member?

Who helps and supports you with your problems? _____

G. MENSTRUAL HISTORY

1. Age periods began? _____

2. Number of pads / tampons used on heaviest day? _____

3. Length of period? _____ (days) # of days between periods?

4. Are your periods usually regular? Yes No

5. Last period started on _____

It seemed Normal Not normal

6. Do you experience, before or with periods, Cramps? Bloating?

Bowel Problems? Emotional changes?

7. Do you have vaginal bleeding after sex? Yes No

8. Do you have vaginal bleeding between menstrual periods? Yes No

J. STI / HIV RISKS:

Number of sex partners in your life? _____ MEN: _____ WOMEN: _____

How many sex partners have you had during the past year? _____

Does your partner have sex with men women both

Do you have (check all that apply) vaginal oral anal

COMMENTS

Have you ever used street drugs?
If yes, when? _____

Have you received blood or blood products prior to 1978? _____

Were any of your partners:
 a street drug user? a hemophiliac?
 infected with HIV / AIDS?
 MSM (men having sex with men)?

STAFF COMMENTS (do not write anything in this space)

To the best of my knowledge, the information I have provided is correct and complete.

Patient Signature _____ Date _____

Staff Signature _____ Date _____

History Reviewed:

Staff Signature _____ Date _____

Staff Signature _____ Date _____