HEALTH HISTORY

Have you ever had problems with any of the following:

Y N Alcohol /Drug Abuse
Y N Cancer, Tumors
Y N Stomach, Colon, Liver, Gallbladder
Y N Headaches, Seizures
Y N Skin
Y N Heart
Y N Lungs, Asthma, Tuberculosis
Y N Thyroid dysfunction/problems
Y N Blood, Blood Clots (head, lungs, legs), Anemia
Y N Head, Eyes, Ears, Nose, Throat
Y N Diabetes
Y N High Blood Pressure / Stroke
Y N Depression, Mental Illness
Y N Kidneys
Y N Blood Clots in the head, lungs, or legs

Other _____

Has your father, mother, brothers, sisters, grandparents ever had any of the following:

Y N Breast or Ovarian Cancer
Y N Diabetes
Y N Heart Attack or Stroke before age 50
Y N High Blood Pressure
Y N High Cholesterol
Y N Cancer _____
Y N Thyroid problems

Y N Have you ever been in the hospital or had surgery?
Y N Have you ever had a blood transfusion?
Y N Do you take any medications?
Y N Do you smoke?

Y N Do you need someone to talk to about your problems?
Y N Do you feel like hurting yourself or someone else?
Y N Do you need help with housing, clothing, food?
Y N Are you hit, yelled at or forced to do anything you don't want to do?
What is the highest grade you completed in school?_____

Y N Do you have problems with irregular periods or spotting between periods?
Y N Do you have back pain or cramping with your periods?
Y N Do you have any 'female problems'?
Y N Have you had any paps that were not normal?
When was your last pap?_____
How old were you when you started having your periods? _____

Y N NA Do you have pain or dryness with sex?
Y N NA Have you ever had a sexually transmitted infection (chlamydia, gonorrhea, trichomonas, genital warts, herpes, syphilis, Hepatitis B or C)?
Y N NA Have any of your past sex partners used IV drugs, had many sex partners, had a sexually transmitted infection, or had sex with both men and women?

Circle all birth control methods you have used in the past: Birth Control Pills Depo Provera (the shot) Patch Condoms Foam/Film Withdrawal (pulling out) IUD Natural Family Planning NuvaRing Explanon

Y N Do you plan on getting pregnant in the next year? Implanon/Norplant Sponge Diaphragm Breast feeding (LAM)

PREGNANCY HISTORY – Include all births live or not

Date Pregnancy Ended	Full Term?	Delivery Type	Weight > 5 lbs?	Problems
		.		

Do you want more information about any of the following?

Stop smoking Weight Loss Diabetes Exercise HIV/AIDS

Other_____

PATIENT SIGNATURE_____DATE_____

Last Td_____ MMR_____ HEP B_____ _____ _____ HPV_____ _____ _____ DES Risk? 1940- 1971 Yes No
Need MMR Yes No Need Hep B (18 or younger) Yes No N/A Need HPV (26 or younger) Yes No N/A
Allergies:_____

Reviewed/updates:_____

2013/ To be completed every five years, reviewed annually