Health History Form – New Patient

Name _____ Date of birth _____ Age _____

To help your provider during today's exam, please complete items 1 through 14, to the best of your knowledge.

1. Social history
   What is your occupation and work environment? _____
   _____
   _____
   How many years of school have you completed? _____

   Relationship status (please circle): Single Married Separated Divorced Widowed Co-habiting Domestic partnered

   Who lives at home with you? _____
   _____
   Are you/do you feel safe there? _____

2. Medication history
   List any current medications and usage (including over-the-counter and vitamins/herbs/supplements):

Medication	Dosage	Frequency	Use

   Are you allergic to any medications/foods/agents?

Medication/Food/Agent	Reaction

3. Menstrual history
   Age at first period: _____
   Age when periods stopped, if menopausal: _____
   First day of last menstrual period: _____
   # of days between periods (day 1- day 1 of next): _____
   Length of each period: _____
   Do you have any problems with your periods? _____
   _____

4. Sexual history
   Are you currently sexually active? _____
   Current sex partner(s) is/are: Male ___ Female ___ Both ___
   How long have you been sexual with your partner(s)?
   _____
   # of sexual partners in the last year? ___ In your lifetime? ____

   Have you ever experienced sexual, verbal, or physical abuse?
   _____

5. Obstetrical history
   Please list all pregnancies, if applicable, including miscarriages, terminations, and ectopic pregnancies.

Year	Type of Preg or Del	Weeks	Sex	Weight	Complications

6. Contraceptive history
   If you are currently using birth control, what method do you use? _____
   How long have you used this method? _____
   Is this method working well for you? _____
   Previous method(s) of birth control? _____
   _____
   _____
   Are you planning a pregnancy this year? _____

7. Menopause history
   If you are menopausal, do you now or have you ever taken hormone therapy? Current _____ Past _____
   If yes, when started and for how long? _____
   Please list any current menopausal symptoms: _____
   _____

8. Gynecological history
   This is my first pelvic exam _____ OR
   Date of last Pap test: _____ Result _____

Have you ever had?	Date
_____ Abnormal Pap test	_____
_____ Colposcopy (microscopic look at cervix)	_____
_____ Freezing/burning/LEEP of the cervix?	_____
_____ Genital herpes	_____
_____ Gonorrhea, Chlamydia, Syphilis (circle)	_____
_____ Condyloma (genital warts)	_____
_____ Pelvic inflammatory disease (PID)	_____
_____ Endometriosis	_____
_____ Uterine fibroids/polyps	_____
_____ Ovarian cyst/polycystic ovaries	_____
_____ Infertility	_____
_____ Exposure to DES	_____

9. Medical history
   Have you/do you have any of the following:
   _____ Anemia
   _____ Asthma
   _____ Blood clot in leg or lung
   _____ Bleeding/clotting disorder
   _____ Breast lump or disease
   _____ Broken bone _____
   _____ Cancer –Type _____
   _____ Depression/anxiety
   _____ Diabetes
   _____ Drug or alcohol dependency
   _____ Eating disorder
   _____ Gallbladder disease
   _____ Heart disease/murmur
   _____ High blood pressure
   _____ High cholesterol
   _____ Kidney stones
   _____ Liver disease
   _____ Migraine headache
   _____ Reflux
   _____ Stroke
   _____ Thyroid disease – Type _____
   _____ Ulcer
   _____ Urinary tract infections
   _____ Other: _____

10. Surgical history
Please list any past surgeries and dates:

Year	Procedure

Have you had any problems with anesthesia? _____

11. Family medical history (parents, siblings, or grandparents only)

	Family Member(s)	Age
Cancer – Type:		
Birth defects		
Depression/anxiety		
Diabetes		
Genetic disease		
Heart disease		
High blood pressure		
High cholesterol		
Mental retardation		
Migraine headache		
Osteoarthritis		
Osteoporosis		
Rheumatoid arthritis		
Stroke		
Thyroid disorders		
Other:		

12. Substance use
Have you/do you drink alcohol (beer, wine, mixed drinks)? _____
If yes, # of drinks/week - Current: _____ Past: _____
Is alcohol a concern for you or others? _____

Cigarette use: Never used _____
Past use _____ Quit date _____
Current use _____ #/day _____
Total # of years of use _____
Are you interested in quitting? _____

Have you/do you use any recreational drugs? _____
If yes, what and when? _____

13. Preventive health
Do you exercise regularly? _____
Type and frequency of exercise _____
_____

Please describe your appetite/eating habits:
_____
_____
_____
Do you eat 4 servings of dairy products a day or take 1000 mg. calcium supplement? _____
# of caffeinated beverages daily: _____

Do you always wear a seat belt? _____
Does your house have a smoke detector? _____
Do you have firearms at home? _____

Have you had a tetanus shot within the last 10 years?_____
Date: _____

Have you had your cholesterol level checked within the last 5 years? _____ Date: _____ Results: _____

Do you do monthly self-breast exams? _____
Have you ever had a mammogram? _____
Date and result of last mammogram: _____
Any previous abnormal mammograms? _____
Date and type of follow-up: _____

When did you last have a dental exam? _____
When did you last have an eye exam? _____

Ever had a colonoscopy? _____ Date: _____
A bone density scan? _____ Date: _____

14. Are you concerned about any of the following?
____ Problems with current birth control
____ Vaginal discharge
____ Pain with intercourse
____ Problems with libido (interest in or enjoying sex)

____ Bleeding/pain between periods
____ Irregular or absent periods
____ Painful periods
____ Heavy menstrual bleeding
____ Premenstrual tension

____ A new or enlarging breast lump
____ Nipple discharge
____ Breast pain

____ Change in size/color of mole or freckle
____ Change in vision or hearing

____ Change in size/firmness of bowel movements
____ Blood in stool
____ Hemorrhoids

____ Pain/swelling in legs
____ Pain in chest, abdomen, or joints
____ Severe headaches

____ Conflict in your family or relationships
____ Often feeling down, depressed or hopeless during the past month
____ Often having little interest or pleasure in doing things during the past month

____ Trouble falling asleep or staying asleep
____ Heat or cold intolerance
____ Unexplained weight loss/gain
____ Abnormal thirst

____ Leaking urine
____ Nighttime urination
____ Pain or discomfort with urination

____ Hot flashes or night sweats
____ Memory loss

____ Fatigue/weakness
____ Dizziness/light-headedness

____ Other – Describe _____
_____
_____
_____
_____
_____
_____
_____