Health History Update

Name _____ Date of birth _____ Age _____

To help your provider during today's exam, please note any **changes** in your status since your last exam.

1. Social system
   Occupation and work environment: _____
   _____
   Education: _____
   Relationship status: _____
   Members in household: _____
   _____

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
   First day of last menstrual period: _____
   # of days between periods: _____
   Length of each period: _____
   List any problems with your periods: _____
   _____
   If menopausal, age when periods stopped: _____
   List any current menopausal symptoms: _____
   _____

4. Sexual system
   Are you currently sexually active? _____
   Current sex partner(s) is/are: male ___ female ___
   How long have you been sexual with your partner(s)?
   _____
   # of sexual partners in the last year? _____
   Are you experiencing any sexual, verbal or physical abuse? _____

5. Contraceptive system
   If you are currently using birth control, what method do you use? _____
   Are you planning a pregnancy this year? _____

6. Medical history
   List any changes in your health since your last exam:
   _____
   _____
   _____

7. Family medical history (parents, siblings, or grandparents only)
   List any changes in your family's health:
   _____
   _____
   _____

8. Substance use
   # of mixed drinks, beer, or wine/week _____
   Is alcohol a concern for you or others? _____
   Cigarette use: _____ #/day
   Are you interested in quitting? _____
   Do you use any recreational drugs? _____
   If yes, what and when? _____
   # of caffeinated beverages daily: _____

9. Preventive health
   Date of last Pap test: _____
   Date of last mammogram: _____
   Do you do monthly self-breast exams? _____

   When was your last dental exam? _____
   Eye exam? _____
   Colonoscopy? _____
   Bone density scan? _____

   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? _____

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

   When was your last tetanus shot? _____
   Have you had your cholesterol level checked within the last 5 years? _____ Date: _____

10. Current concerns
    Do you have any questions, problems, or concerns?
    _____
    _____
    _____
    _____
    _____
    _____
    _____