

Medical History Form

Name:	DOB: / /	Date:
-------	----------	-------

Special assistance needed for care	<input type="checkbox"/> None <input type="checkbox"/> Lifting Assistance <input type="checkbox"/> Wheelchair Accessibility <input type="checkbox"/> Interpreter <input type="checkbox"/> Other _____
---	--

CURRENT MEDICATIONS: List all current prescriptions and over-the-counter medications including dose and frequency

ALLERGIES:

<input type="checkbox"/> No Known Allergies	<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Cephalosporins	<input type="checkbox"/> Codeine	<input type="checkbox"/> Erythromycin
<input type="checkbox"/> Iodine	<input type="checkbox"/> Latex	<input type="checkbox"/> Lidocaine	<input type="checkbox"/> Demerol	<input type="checkbox"/> Morphine
<input type="checkbox"/> NSAIDS (Advil, Aleve)	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Salicylates	<input type="checkbox"/> Succinimides	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Tetracyclines	<input type="checkbox"/> Pertussis Vaccine	<input type="checkbox"/> Other _____		

Food Allergies:

<input type="checkbox"/> None	<input type="checkbox"/> Eggs	<input type="checkbox"/> Dairy	<input type="checkbox"/> Nuts
<input type="checkbox"/> Shellfish	<input type="checkbox"/> Gluten	<input type="checkbox"/> Other _____	

MEDICAL HISTORY: (Select all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> Anemia	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> Blood/Clotting Disorder	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Depression
<input type="checkbox"/> DES Exposure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> DVT/PE (blood clot in leg/Lungs)	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Fracture
<input type="checkbox"/> GERD/Acid Reflux	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> GI Issues (bowel trouble/IBS)	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Rectal Cancer
<input type="checkbox"/> Seizures	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Vision or Hearing Impairment
<input type="checkbox"/> Other _____				

GYN HISTORY: (Select all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> Breast problems	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Fibroids	<input type="checkbox"/> Pelvic inflammatory disease
<input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS)	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Cervical Cancer	<input type="checkbox"/> Endometrial Cancer	<input type="checkbox"/> Ovarian Cancer
<input type="checkbox"/> Uterine Cancer	<input type="checkbox"/> Other _____			

SURGICAL HISTORY: (Select all that apply)

<input type="checkbox"/> None	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Breast Augmentation	<input type="checkbox"/> Breast Biopsy
<input type="checkbox"/> Breast Reduction	<input type="checkbox"/> Breast Surgery	<input type="checkbox"/> D&C	<input type="checkbox"/> Hysteroscopy	<input type="checkbox"/> Foot Surgery
<input type="checkbox"/> Gallbladder Removal	<input type="checkbox"/> Hip Surgery	<input type="checkbox"/> Knee Surgery	<input type="checkbox"/> Oral Surgery	<input type="checkbox"/> Shoulder Surgery
<input type="checkbox"/> Thyroid Surgery	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Bilateral Tubal ligation	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Ovaries Removed
<input type="checkbox"/> Laparoscope	<input type="checkbox"/> Uterine Ablation	<input type="checkbox"/> C-Section	<input type="checkbox"/> Other _____	

HEALTH MAINTENANCE: answer all that apply with Date and Results

Last Pap Smear	
Last HPV Test	
History of abnormal pap If yes, indicate treatment	<input type="checkbox"/> None <input type="checkbox"/> Yes <input type="checkbox"/> No treatment <input type="checkbox"/> Freezing <input type="checkbox"/> LEEP/cone <input type="checkbox"/> Laser
Last Routine Screening Labs	
Last Mammogram	
Last Colonoscopy	
Last Bone Density Scan/DEXA	

MENSTRUAL HISTORY – If you ARE having menstrual cycles, please answer the following. Otherwise, skip to next section

At what age did your periods start	
What was the first day of your last period	
What is the length of time between periods	<input type="checkbox"/> Irregular <input type="checkbox"/> 21-32 days <input type="checkbox"/> less than 21 days <input type="checkbox"/> 33-44 days <input type="checkbox"/> more than 45 days
How long does your period last	<input type="checkbox"/> 2-7 days <input type="checkbox"/> longer than 7 days
How would you describe your flow	<input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy
Do you have pain/cramping associated with your periods	<input type="checkbox"/> No pain/cramping <input type="checkbox"/> Mild discomfort <input type="checkbox"/> Moderate discomfort <input type="checkbox"/> Severe pain/cramping
Any other symptoms associated with your period	<input type="checkbox"/> None <input type="checkbox"/> Headaches <input type="checkbox"/> Bloating <input type="checkbox"/> Irritability <input type="checkbox"/> Migraines <input type="checkbox"/> Weight Gain <input type="checkbox"/> Mood swings <input type="checkbox"/> Nausea <input type="checkbox"/> Bowel issues

MENSTRUAL HISTORY – If you ARE NOT having menstrual cycles, please answer the following.

Reason for no menses	<input type="checkbox"/> Menopausal <input type="checkbox"/> Pregnant/Breastfeeding <input type="checkbox"/> IUD in place <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Unknown
Menopausal - What age did this occur	
Menopausal - Any current menopausal symptoms	<input type="checkbox"/> None <input type="checkbox"/> Hot Flashes/Night Sweats <input type="checkbox"/> Memory Loss <input type="checkbox"/> Headaches <input type="checkbox"/> Irritability <input type="checkbox"/> Weight gain <input type="checkbox"/> Decrease Libido <input type="checkbox"/> Vaginal Dryness
Menopausal - Are you taking any treatments	<input type="checkbox"/> None <input type="checkbox"/> Hormones <input type="checkbox"/> OTC treatments
IUD - What type is in place	<input type="checkbox"/> Mirena <input type="checkbox"/> Liletta <input type="checkbox"/> Kyleena <input type="checkbox"/> Skyla <input type="checkbox"/> Paragard <input type="checkbox"/> Unknown
IUD – When was it placed	

SEXUAL HISTORY

Have you ever been sexually active	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to next section)
Are you currently sexually active	<input type="checkbox"/> Yes <input type="checkbox"/> No
Age of first sexual encounter	
Have you had more than 5 lifetime partners	<input type="checkbox"/> Yes <input type="checkbox"/> No
Type of birth control	<input type="checkbox"/> Nothing <input type="checkbox"/> Withdrawal <input type="checkbox"/> Condoms <input type="checkbox"/> Diaphragm <input type="checkbox"/> Spermicide <input type="checkbox"/> Oral Contraceptives <input type="checkbox"/> Contraceptive Patch <input type="checkbox"/> Contraceptive Vaginal Ring <input type="checkbox"/> Depo Provera <input type="checkbox"/> Nexplanon <input type="checkbox"/> IUD <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Hysterectomy
Have you ever been diagnosed with a Sexually Transmitted Infection (STI)	<input type="checkbox"/> None <input type="checkbox"/> Human Papilloma Virus (HPV) <input type="checkbox"/> Chlamydia <input type="checkbox"/> Herpes Simplex Virus (HSV) <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomoniasis <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Human Immunodeficiency Virus (HIV)

BLADDER HEALTH

Do you ever leak urine when you cough, sneeze, laugh or exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you ever leak urine on the way to the bathroom or can't get to the bathroom on time?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a history of recurrent urinary tract infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you go to the bathroom frequently and/or get up multiple times at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No

OB HISTORY

Total # of Pregnancies		Total living children	
# of full-term pregnancies (37 weeks or greater)		# of preterm pregnancies (less than 37 weeks)	
# of miscarriages/abortions		# of ectopic (tubal) pregnancies	

Please fill out the following to the best of your recollection regarding your prior pregnancies:

	Date MO/YR	SEX	GA WEEKS	TYPE of DELIVERY	BIRTH WEIGHT	ANESTHESIA	LENGTH of LABOR	WEIGHT GAIN
PREG 1		M or F		Vaginal or C-Section	lbs. oz.			
Comments and complications:								
PREG 2		M or F		Vaginal or C-Section	lbs. oz.			
Comments and complications:								
PREG 3		M or F		Vaginal or C-Section	lbs. oz.			
Comments and complications:								
PREG 4		M or F		Vaginal or C-Section	lbs. oz.			
Comments and complications:								

Patient Name _____ Date of Birth _____

FAMILY HISTORY: Please check all that apply Family history unknown/adopted

Medical Condition	Mother	Father	Sibling	Child	Mat GM	Mat GF	Pat GM	Pat GF
Bleeding Disorder								
Heart Disease								
Diabetes								
Hypertension								
Breast Cancer								
Ovarian Cancer								
Colon Cancer								
Uterine Cancer								
Stroke								
Thyroid Disorder								
Osteoporosis								
Auto Immune Disorders								
Mental Illness								
Other								

SOCIAL HISTORY

Tobacco/Smoking

Do you now or have you ever smoked or used tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to next section)
Age you started smoking	
Type of Product	<input type="checkbox"/> Cigarettes <input type="checkbox"/> e-cigarette <input type="checkbox"/> Vape <input type="checkbox"/> Chewing tobacco
Amount of Use	<input type="checkbox"/> Daily <input type="checkbox"/> Some days but not every day <input type="checkbox"/> 5 or less/day <input type="checkbox"/> 6-10/day <input type="checkbox"/> 11-20/day <input type="checkbox"/> 21-30/day <input type="checkbox"/> more than 31/day
Former Smoker – Age you stopped	

Alcohol

Have you had a drink containing alcohol in the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to next section)
How often did you have a drink containing alcohol in the last year	<input type="checkbox"/> Less than monthly <input type="checkbox"/> 2-4 times per month <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> 4 or more times per week

Recreational Drugs

Have you ever used any recreational drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to next section)
Type of Use	<input type="checkbox"/> Marijuana <input type="checkbox"/> Heroin <input type="checkbox"/> Cocaine <input type="checkbox"/> Crack <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Opiates <input type="checkbox"/> Ecstasy <input type="checkbox"/> LSD <input type="checkbox"/> PCP <input type="checkbox"/> Ketamine <input type="checkbox"/> Other _____
How long since you last used	
How often do you use	
Are you interested in a treatment program	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

Domestic Violence/Abuse

Have you ever or are you currently experiencing any type of abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No (Skip to next section)
Type of Abuse and Status	<input type="checkbox"/> Verbal <input type="checkbox"/> Physical <input type="checkbox"/> Sexual
Abuse Status	<input type="checkbox"/> History in the past <input type="checkbox"/> Have a restraining order <input type="checkbox"/> Feels unsafe at home <input type="checkbox"/> have a safety plan
Has your partner ever threatened you or made you feel afraid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your partner or someone important to you hurt you physically or emotionally?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other

Would you object to blood products in the event of an emergency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

Immunizations: Have you had any of the following?

Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year	Gardasil	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year
Tdap	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year	Influenza	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year
Rubella	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year	COVID	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year

Patient Name _____ Date of Birth _____

