



Patient History Form

Patient ID: _____

Name: _____

Date of Birth: _____

REASON FOR VISIT: _____

Do you have any complaints today? **No / Yes** (please explain): _____

Who is your primary care physician? _____

Preferred Pharmacy? _____

Medical History:

Past medical history (please circle any/all that apply):

Anemia	Blood Transfusion	Intestinal Disease	Lung Disease
Arthritis	Diabetes	Irritable Bowe Syndrome	Lupus
Asthma	Depression	Kidney Disease	Osteoporosis
Autoimmune	Heart Disease	Kidney Stones	Reflux
Bladder Issues	Hypertension.	Hepatitis	Stroke
Blood Clot	High Cholesterol	Liver Disease	Thyroid
Cancer (specify) _____	Other (specify): _____		

Surgical History:

Have you ever had a surgery in your life? **No / Yes**

If yes, please complete the following (with year, if known):

Surgery	Year

Have you ever had complications from anesthesia? **No / Yes** (specify):

Have you ever had a blood transfusion? **No / Yes** (year and reason):

Allergies:

Do you have any medication allergies? **No / Yes**

Are you allergic to: Latex Peanuts Iodine/shellfish IV contrast Eggs

Medication	Reaction

Medications:

Do you take any **medications / supplements** on a daily basis? **No / Yes**

Medication	Dose



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Obstetric History:

How many total pregnancies have you had in your life? _____

Have you ever had a miscarriage, ectopic (tubal) pregnancy, abortion (Year): _____

#	Year	Gestational Age	Type of Delivery (Vaginal or Cesarean)	Baby's Sex and Weight	Complications	Living
<u>1</u>						
<u>2</u>						
<u>3</u>						
<u>4</u>						
<u>5</u>						

GYN History:

Last menstrual period? _____ Age at first menstruation: _____

Are your periods: **Regular/monthly** **More Frequent** **Less Frequent** **Absent**

How many days do your periods last? **< 3** **4-7** **> 7**

Do you experience: **Cramping** **Heavy Bleeding** **Clots**

Are you sexually active? **No / Yes**

Are you using any form of birth control? **No / Yes** (specify):

Abstinence **Condoms** **Patch/Ring** **Depo Provera** **IUD**
Oral Contraception **Tubal Ligation** **Vasectomy** **Withdraw** **Other:** _____

Age of first sexual # of Sexual Partners: _____

When was your last Pap smear? _____ Result: **Normal / Abnormal**

Have you ever had an abnormal Pap smear in your life? **No / Yes**

Have you ever been diagnosed with one of the following: **No / Yes**

HPV **Genital Warts** **Gonorrhea** **Chlamydia** **Syphilis**
Herpes **HIV** **Hepatitis B** **Hepatitis C** **Chancroid**

Do you have a history of:

Endometriosis **Fibroids** **Infertility** **Painful Periods** **STI**

Do you do self-breast exams? **No / Yes**

If yes, have you noticed any masses? **No / Yes** (specify): _____

If yes, have you noticed any pain? **No / Yes** (specify) _____

Have you ever had a mammogram? **No / Yes**

If yes, when and where was your last mammogram? _____ Result: **Normal / Abnormal**
(specify): _____

Social History:

Occupation: _____

Marital Status: **Single** **Married** **Divorced** **Widowed** **Separated**

Do you smoke? **No / Yes**

If yes, how many packs per day? _____ How many years? _____



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Electronic cigarette use? **No / Yes** How many years? _____

Do you drink alcohol? **No / Yes** If yes, how many drinks per week? _____

Do you currently use any illegal drugs? **No / Yes** If yes, please list: _____

Have you ever used any illegal drugs in the past? **No / Yes** If yes, please list: _____

Do you drink caffeine? **No / Yes** If yes, how many servings per day? _____

Please list any exercise that you do: _____

Physical / sexual abuse : **No / Yes Please specify:** _____

Immunizations:

Have you received all recommended childhood vaccines? **No / Yes**

Have you ever had the HPV (Gardasil) vaccine? **No / Yes** Year: _____

If no, are you interested in getting this vaccine? **No / Yes**

Have you ever had a tetanus shot? **No / Yes** If yes, most recent year received: _____

Other Screening Examinations:

Have you ever had a colonoscopy? **No / Yes** If yes, when: _____

Result: **Normal / Abnormal** (specify): _____

Have you ever had a bone density scan? **No / Yes** If yes, when: _____

Other (specify): _____

Please circle any of the following that apply or that you may be experiencing: (current or previous)

- Weight Changes Fever/Chills Difficulty Sleeping Hearing Loss Sinus Congestion Chest Pain Palpitations
- Difficulty Breathing Bloody Sputum Nausea/Vomiting Diarrhea Constipation Bloody Stools Frequent Urination
- Painful Urination Blood in Urine Leaking Urine Irregular/Heavy Bleeding Vaginal Discharge Low Sex Drive
- Sexual Dysfunction Recurrent Yeast Infection Painful Intercourse Pelvic Pain Skin Rashes Breast Pain
- Breast Discharge Breast Mass Seizures Fainting Mood Changes Anxiety/Depression Heat/Cold Intolerance
- Excessive Thirst Excessive Urination Hot Flashes Abnormal Bruising/Bleeding

Family History:

Please indicate any family members that have been diagnosed with the following: (Examples include: Mother, father, brother, sister, child, grandmother, grandfather)

Anemia	Blood Transfusion	Intestinal Disease	Lung Disease
Arthritis	Diabetes	Irritable Bowel Syndrome	Lupus
Autoimmune	Heart Disease	Kidney Stones	Reflux
Bladder Issues	Hypertension	Hepatitis	Stroke
Blood Clot	High Cholesterol	Liver Disease	Thyroid
Other (specify): _____			
Congenital Abnormalities: _____			
GYN Cancer (breast, uterus, ovary, cervix, etc.) _____			
Other Cancers (lung, colon, prostate, etc.): _____			