Patient History Form

PLACE PATIENT LABEL HERE

NAME _____ Date ____ /____ /____

Patient ID#_____ D.O.B.____ /____ /____ Age_____

A. REVIEW OF SYSTEMS:		
YES	**NO**	**GENERAL**
		1. Is your health generally good?
		2. Unexplained weight loss or gain of more than 10 lbs. in the past year?
		3. Night sweats / hot flashes?
		4. Cancer? If yes, where / when?
		5. Tobacco use? If yes, for how many years? _____ If yes, ❑ smoking? How many/day? ❑ chewing tobacco?
		6. Alcohol use? If yes, how many drinks/week?
		7. Are you being treated for any illness/condition now? If yes what?
		8. Do you currently take medicine: prescription, over-the-counter, or herbal? If yes, what? Do you take any folic, vitamin, or nutritional acid supplements?
		9. Birth defects or genetic problems?
		10. Eye problems (except glasses or contacts)?
		11. Hearing problems?
		12. Frequent nosebleeds?
		13. Frequent sore throat?
CARDIO-RESPIRATORY		
		14. Mitral valve prolapse?
		15. Heart murmur?
		16. Varicose veins?
		17. Blood clots (head / leg / lungs)?
		18. Stroke or stroke-like problems?
		19. High blood pressure?
		20. High cholesterol?
		21. Chronic cough or other breathing problems / asthma?
		22. Tuberculosis or exposure to tuberculosis?
GASTROINTESTINAL		
		23. Stomach or bowel problems?
		24. Liver problems (hepatitis or tumor, etc.)?
		25. Gallbladder problems?
GENITOURINARY		
		26. Bladder, urine leaks, or kidney problems?
		27. Uterine fibroids?
		28. Ovarian cysts?
		29. Breast lump or nipple discharge?
		30. Vaginal discharge that itches, burns, or has a bad odor?
		31. Endometriosis?
		32. Pain with sex? Other sex problems?
		33. Previous abnormal pap result? When?
		34. Did your mother take DES to prevent a miscarriage when she was pregnant with you?
		35. History of sexually transmitted infection? If yes, check type: ❑ Chlamydia? ❑ Gonorrhea? ❑ Genital warts? ❑ Herpes? ❑ Syphilis? ❑ PID ❑ HIV/AIDS?
MUSCULOSKELETAL		
		36. ❑ Arthritis? ❑ Osteoporosis? ❑ Other?_____
SKIN		
		37. Acne or other skin problems? If yes, what?_____ ❑ Tattoo? ❑ Piercing? If yes, where? _____
NEUROLOGICAL		
		38. Migraine headaches / Aura (diagnosed by MD / NP / PA)?
		39. Seizures / epilepsy?
		40. Numbness in arms / legs (recurring)?
PSYCHOLOGICAL		
		41. Depression requiring treatment? Have you ever considered suicide? ❑ Yes ❑ No Other psychological problems?

A. (cont'd) REVIEW OF SYSTEMS		
YES	**NO**	**ENDOCRINE**
		42. Thyroid problems?
		43. Diabetes?
HEMATOLOGICAL/LYMPHATIC		
		44. Anemia (Low Iron)?
		45. Sickle cell disease / trait?
		46. Blood clotting disorder?
ALLERGY		
		47. Are you allergic to any drug, medication, latex, or other substance, including local anesthesia? If yes, to what? Type of reaction:
IMMUNIZATION (Check the ones you have received)		
		48. ❑ Diphtheria?
		49. ❑ Hepatitis A?
		50. Hepatitis B ❑ shot 1? ❑ shot 2? ❑ shot 3?
		51. Human Papillomavirus (HPV) ❑ shot 1? ❑ shot 2? ❑ shot 3?
		52. ❑ Measles/Mumps/Rubella (MMR)?
		53. ❑ Meningococcal?
		54. ❑ Pneumococcal?
		55. ❑ Tetanus?
		56. ❑ Varicella (chicken pox)?
		57. ❑ Other

B. HOSPITALIZATION AND SURGERIES	
Year	**Reason**

D. FAMILY HISTORY

Are you adopted? ❑ Yes ❑ No

Have your biological family (parents, brothers, sisters) had any of the following?

YES	NO	**Diagnosis**	**Relative**
		Osteoporosis?	
		Diabetes?	
		Heart disease / heart attack / stroke before age 50?	
		High blood cholesterol?	
		Genetic problems?	
		Cancer? If yes, please specify_____	
		Blood clots?	
		Other?	

ADDITIONAL COMMENTS / EXPLANATIONS (by number)

PLEASE COMPLETE OTHER SIDE

Patient History Form

PLACE PATIENT LABEL HERE

NAME _____ Date _____ /_____ /_____

E. PREGNANCY HISTORY ❑ never pregnant

DELIVERED					ABORTION / MISCARRIAGE			
Mo.	Yr.	Vag.	C-Sec.	Birth Weight	Year	Weeks	Spont.	Induced

F. CONTRACEPTIVE HISTORY

Current birth control method? How long used?
Any problems with this method? ❑ Yes ❑ No
If yes, what?

What method do you want to use now?

Total number of children desired?

Are you planning a pregnancy in the NEXT year? ❑ Yes ❑ No

If not, what would you do if you become pregnant within the NEXT year?

Which of the following methods have you used in the past?

METHOD	COMMENT/PROBLEM
❑ Abstinence?	
❑ Tubal? ❑ Vasectomy? ❑ Hysterectomy?	
❑ Birth Control Pill?	
❑ The Patch?	
❑ The Ring?	
Implant: ❑ Norplant? ❑ Implanon?	
❑ Depo-Provera (The Shot)?	
❑ IUD?	
❑ Condoms?	
❑ Diaphragm? ❑ FemCap? ❑ Lea's Shield?	
❑ Sponge? ❑ Spermicide?	
❑ Rhythm?	
❑ NFP (Natural Family Planning)?	
❑ Withdrawal?	

G. SOCIAL HISTORY

❑ Emotional? ❑ Relationship problems?	
Death of ❑ Family member? ❑ Friend?	
❑ Job loss? ❑ Financial problems?	
Problems in ❑ Living arrangements? ❑ School?	
❑ Legal problems? ❑ Arrests? ❑ Divorce?	
Do you have any parental problems?	
Are you physically abused?	
Has anyone forced you to have sex?	
Are you sexually abused?	
Are you afraid of your ❑ Partner? ❑ Family member?	
Who helps and supports you with your problems?	

H. MENSTRUAL HISTORY

1. Age periods began?
2. Number of pads / tampons used on heaviest day?
3. Length of period? (days) # of days between periods?
4. Are your periods usually regular? ❑ Yes ❑ No
5. Last period started on _____
   It seemed ❑ Normal ❑ Not normal
6. Do you experience, before or with periods, ❑ Cramps? ❑ Bloating?
   ❑ Bowel problems? ❑ Emotional changes?
7. Do you have vaginal bleeding after sex? ❑ Yes ❑ No
8. Do you have vaginal bleeding between menstrual periods? ❑ Yes ❑ No

I. STI / HIV RISKS

Number of sex partners in your life? MEN WOMEN
How many sex partners have you had during the past year?

Does your partner have sex with ❑ men ❑ women ❑ both?

Do you have (check all that apply) ❑ vaginal ❑ oral ❑ anal sex?

	COMMENTS
Have you ever used street drugs? If yes, when? _____	
Have you received blood or blood products prior to 1978?	
Were any of your partners: ❑ a street drug user? ❑ a hemophiliac? ❑ infected with HIV / AIDS? ❑ MSM (men having sex with men)?	
Have you ever shared needles? Examples: Injecting drugs, tattooing, piercing?	

STAFF COMMENTS (do not write anything in this space)

To the best of my knowledge the information I have provided is correct and complete.

Patient Signature Date

Staff Signature Date

History reviewed:

Staff Signature Date

Staff Signature Date