Patient Name	Date of Birth	Patient ID

Today's Date:

Health History Form

Please review this form to ensure that your health information is accurate. You will be able to discuss any questions or concerns that you have with your provider during your appointment.

Medications

List all current medications. Include prescribed and over-the-counter drugs, such as vitamins and inhalers.

Medication	Dosage	Frequency

Surgical History include Month/Year

Check all surgeries that apply.

- ☐ Breast Biopsy
- ☐ GI-Weight Loss Surgery
- ☐ Breast-Implants
- ☐ Breast-Lumpectomy
- ☐ Breast-Mastectomy
- ☐ Breast-Reconstruction
- ☐ Breast-Reduction
- ☐ Cancer-Surgery
- ☐ Cardiac-Transplant Surgery
- ☐ Cardiac- Bypass
- ☐ Cardiac- Stents
- ☐ Cardiac-other surgery
- ☐ Derm-Skin Surgery
- ☐ ENT-Adenoidectomy/Tonsillectomy
- ☐ Endo-Thyroid Surgery
- ☐ Endo-other surgery
- ☐ GYN-Endometrial Ablation
- ☐ GYN-Fibroid Surgery/Myomectomy
- ☐ GYN-Hysterectomy, Abdominal
- ☐ GYN-Hysterectomy, Laparoscopic
- ☐ GYN-Hysterectomy, Supracervical
- ☐ GYN-Hysterectomy, Vaginal
- ☐ GYN-Hysterectomy
- ☐ GYN-Hysteroscopy
- ☐ GYN-LEEP/Cone Biopsy
- ☐ GYN-Labial Abscess I&D
- ☐ GYN-Laparotomy
- ☐ GYN-Laparoscopy
- ☐ GYN-Ovarian Surgery
- ☐ GYN-Pelvic Prolapse Surgery
- ☐ GYN-Removal of Both Ovaries
- ☐ GYN-Removal of Left Ovary

- ☐ ENT-other surgery
- ☐ Eye-Cateract Surgery
- ☐ Eye-Other Surgery
- ☐ GI-Appendectomy
- ☐ GI-Cholecystectomy
- ☐ GI-Colon Resection
- ☐ GI-Colonoscopy
- ☐ GI-Hemorrhoid Surgery
- ☐ GI-Hernia Repair
- ☐ GI-Splenectomy
- ☐ GI- Weight Loss Surgery
- ☐ GI-Other Surgery
- ☐ GYN-Bartholin's Gland Surgery
- ☐ GYN-Colposcopy
- ☐ GYN-Cryotherapy of the Cervix
- ☐ GYN-Cystoscopy
- ☐ GYN-D&C
- ☐ GYN-Removal of Right Ovary
- ☐ GYN-Tubal Ligation/Sterilization
- ☐ GYN-Urinary Incontinence Surgery
- ☐ GYN-Vulvar Surgery
- ☐ GYN-other surgery
- ☐ Neuro-Back Surgery
- ☐ Neuro-Brain Surgery
- ☐ OB-Cerclage
- ☐ OB-Cesarean Section
- ☐ Ortho-Joint Replacement
- ☐ Ortho-Knee Surgery
- ☐ Ortho-Hip Replacement
- ☐ Plastic-Cosmetic Surgery
- ☐ Pulmonary-Surgery
- ☐ Surgery-Other
- ☐ Uro-Kidney Stone Surgery
- ☐ Uro-Kidney Surgery

GYN History

1. 1st day of last menstrual period

   ____ / _____

2. Date of Last Mammogram

   ____ / _____

3. Date of Last Colonoscopy

   ____ / _____

4. Date of Last Bone Density Test

   ____ / _____

5. Date of Last Pap Smear

   ____ / _____

6. HPV Test (Circle one)

   Positive Negative Not Applicable

7. Current Birth Control Method: (Circle one)

   Abstinence Condoms Depo Provera Diaphragm

Essure	Hysterectomy	IUD	Menopause
Nexplanon	Patch	Progestin Only Pills	Combined Oral Contraceptive Pills
Planning Pregnancy	Rhythm	Ring	Spermicide
Tubal ligation	Vasectomy - Partner	Withdrawal	None

8. HPV Vaccination (Circle one)

   Completed Not Completed Not Applicable

9. History of abnormal PAP (Circle one)

   Yes No

10. History of Cervical Dysplasia (Circle one)

    Yes No

11. History of Vulvar Dysplasia (Circle one)

    Yes No

12. Sexually Active? (Circle one)

    Yes No

13. Age at first menstrual period _____

14. Age at first intercourse _____

15. Total Lifetime Partners _____

16. Sexual Orientation (Circle one)

    Heterosexual Homosexual Bisexual Transgender

17. History of Sexually Transmitted Infection (Circle one)

    Yes No

18. Age at Menopause _____

19. Post Menopausal Hormone Use (Circle one)

    Never Past Use Current Use

20. History of Endometriosis (Circle one)

    Yes No

21. History of Fibroids (Circle one)

    Yes No

22. History of Infertility (Circle one)

    Yes No

23. History of Recurrent Ovarian Cysts (Circle one)

Yes No

24. History of PCOS (Circle one)

Yes No

Allergies

List all known allergies.

Allergy	Reaction(s)	Date of First Reaction (approx.)	Not Current
_____	_____	___ / _____	
_____	_____	___ / _____	
_____	_____	___ / _____	
_____	_____	___ / _____	

Family History include whichside – Mother's, fathers

Check all diseases and conditions that apply.

- ☐ Coagulation disorder — Family member(s):_____
- ☐ Stroke — Family member(s):_____
- ☐ Dementia — Family member(s):_____
- ☐ Diabetes — Family member(s):_____
- ☐ Disorder of thyroid gland — Family member(s):_____
- ☐ Endometrial cancer — Family member(s):_____
- ☐ Heart disease — Family member(s):_____
- ☐ Hereditary disease — Family member(s):_____
- ☐ High cholesterol — Family member(s):_____
- ☐ High blood pressure — Family member(s):_____
- ☐ Skin cancer — Family member(s):_____
- ☐ Uterine cancer — Family member(s):_____
- ☐ Malignant neoplastic disease — Family member(s):_____
- ☐ Breast cancer — Family member(s):_____
- ☐ Cervical cancer — Family member(s):_____
- ☐ Colon cancer — Family member(s):_____
- ☐ Lung cancer — Family member(s):_____
- ☐ Ovarian cancer — Family member(s):_____

☐ Pancreatic cancer Family member(s):_____

☐ Osteoporosis Family member(s):_____

☐ Other Family member(s):_____

Past Medical History

Check all diseases and conditions that apply.

☐ Cancer- Genetic Screening

☐ Cancer- Breast

☐ Cancer- Cervical

☐ Cancer- Colon

☐ Cancer- Endometrial/Uterine

☐ Cancer- Lung

☐ Cancer-Other

☐ Cancer- Ovary

☐ Cancer- Skin

☐ Cancer- Vaginal

☐ Cancer- Vulvar

☐ Vascular-Aneurysm

☐ Cardiology-Heart Arrhythmia

☐ Cardiology-Heart Attack

☐ Cardiology-Heart Disease

☐ Cardiology-Heart Murmur/Mitral Valve Prolapse

☐ Cardiology-High Blood Pressure

☐ Cardiology-High Cholesterol

☐ Cardiology-Other

☐ Dermatology-Acne

☐ Dermatology-Eczema/Psoriasis

☐ Endocrinology- Diabetes

☐ Dermatology-Other

☐ Endocrinology- History of Gestational Diabetes

☐ Endocrinology- Prolactinoma

☐ GYN- PCOS

☐ GYN- Dysplasia

☐ GYN- Fibroids

☐ GYN-Other

☐ Hematology-Anemia

☐ Hematology-Bleeding Disorder

☐ Hematology-Blood Clotting Disorder/Factor V Leiden

☐ Hematology-Blood Transfusion

☐ Hematology-DVT/Pulmonary Embolism

☐ Hematology-Other

☐ ID-Chicken Pox/Shingles

☐ ID-HIV

☐ ID-MRSA

☐ ID- Tuberculosis/Positive PPD

☐ Other Infectious Disease

☐ Neurology- Headaches/Migraines

☐ Neurology- Dementia

☐ Neurology-Other

☐ Neurology- Seizures/Epilepsy

☐ Neurology- Stroke/TIA

☐ Ortho-Chronic Back Pain

☐ Ortho-Arthritis

☐ Ortho-Fractures

☐ Ortho-Other

☐ Neurology- Multiple Sclerosis

- ☐ Endocrinology- Osteoporosis
- ☐ Osteopenia (low bone mass)
- ☐ Endocrinology- Vitamin Deficiency
- ☐ Endocrinology-Other
- ☐ Endocrinology- Hypothyroidism
- ☐ Endocrinology- Glucose Intolerance/Insulin Resistance
- ☐ Endocrinology- Hyperthyroidism
- ☐ ENT- Hearing Loss
- ☐ ENT- Seasonal Allergies/Allergic Rhinitis
- ☐ ENT-Other
- ☐ Eyes- Glaucoma
- ☐ Eyes- Vision Loss/Macular Degeneration
- ☐ Eyes-Other
- ☐ GI- Colon Polyps
- ☐ GI- Crohn's/Ulcerative Colitis
- ☐ GI- Gallbladder Disease
- ☐ GI- Hemorrhoids
- ☐ GI- Irritable Bowel Syndrome
- ☐ GI- Liver Disease/Hepatitis
- ☐ GI-Other
- ☐ GI- Reflux/Ulcers
- ☐ GYN- Infertility
- ☐ GYN- Endometriosis
- ☐ Nephrology-Renal Disease
- ☐ Attention Deficit Disorder (ADD) (ADHD)
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Eating Disorder
- ☐ Psychological-Other
- ☐ PMS (Premenstrual syndrome) or PMDD (Premenstrual dysphoric di
- ☐ Pulmonary- Asthma
- ☐ Pulmonary- COPD/Emphysema
- ☐ Pulmonary-Other
- ☐ Pulmonary- Sleep Apnea
- ☐ Rheumatology-Arthritis
- ☐ Rheumatology-Autoimmune Disease
- ☐ Rheumatology-Fibromyalgia/Chronic Pain
- ☐ Rheumatology-Other
- ☐ Urology- Recurrent Urinary Tract Infections
- ☐ Urology- Hematuria (Blood in Urine)
- ☐ Urology- Interstitial Cystitis
- ☐ Urology-Other
- ☐ Urology- Stones
- ☐ Urology- Urinary Incontinence
- ☐ Weight Management/Obesity

Social History

1. Smoking Status (Circle one)

Never smoker	Former smoker	Current every day smoker	Current some day smoker
Smoker - current status unknown	Unknown if ever smoked		

2. Smoking - How much? (Circle one)

None 1 PPW 2 PPW 1/4 PPD

1/2 PPD 1 PPD 1 1/2 PPD 2 PPD

3+ PPD

3. Smoking pre-pregnancy (Circle one)

No Yes 1 PPW 2 PPW

.25 PPD .5 PPD 1 PPD 1.5 PPD

2 PPD 3 PPD

4. Alcohol intake (Circle one)

None Occasional Moderate Heavy

5. Alcohol pre-pregnancy (Circle one)

None Occasional Moderate Heavy

6. Illicit drugs _____

7. Illicit drugs pre-pregnancy _____

8. Caffeine intake (Circle one)

None Occasional Moderate Heavy

9. Exercise level (Circle one)

None Occasional Moderate Heavy

10. Diet (Circle one)

Regular Vegetarian Vegan Gluten free

Specific Carbohydrate Cardiac Diabetic

11. Country of birth _____

12. Ethnic Background _____

13. Education (Circle one)

Less than 8th Grade 8 9 10

11 12 2 Year College 4 Year College

Post Graduate

14. Occupation _____

15. Sexual orientation (Circle one)

Heterosexual Homosexual Bisexual

16. Religion _____

17. Is blood transfusion acceptable in an emergency? (Circle one)

Yes No

18. Marital status (Circle one)

Unknown Married Single Divorced

Separated Widowed Domestic Partner

19. History of domestic violence (Circle one)

Yes No

20. General stress level (Circle one)

Low Medium High

21. Seat belts used routinely (Circle one)

Yes No

22. Hobbies/Activities _____

23. Blind or serious difficulty seeing (Circle one)

Yes No

24. Deaf or serious difficulty hearing (Circle one)

Yes No

25. Difficulty concentrating, remembering or making decisions (Circle one)

Yes No

26. Difficulty doing errands alone (Circle one)

Yes No

27. Difficulty dressing or bathing (Circle one)

Yes No

28. Difficulty walking or climbing stairs (Circle one)

Yes No

29. Tobacco-years of use _____

30. Are you currently sexually active with anyone who has traveled (within the last 12 weeks) to a Zika-affected area? (Circle one)

Yes No

31. Have you had sexual relations with anyone who has been positively diagnosed with Zika virus within the last 6 months? (Circle one)

Yes No

32. Have you or your sexual partner experienced any of the following symptoms? Fever, Rash, Joint Pain, Conjunctivitis (Circle one)

Yes No

33. Have you or your sexual partner recently (within the last 12 weeks or during a current pregnancy) traveled to any country in South America and/or the Caribbean? (Circle one)

Yes No

Immunizations

Check all vaccinations you have received.

☐ Flu vaccine	Date received (approx.) ____ / _____
☐ Gardasil vaccine	Date received (approx.) ____ / _____
☐ Hepatitis A vaccine	Date received (approx.) ____ / _____
☐ Hepatitis B vaccine	Date received (approx.) ____ / _____
☐ MMR (measles, mumps, and rubella) vaccine	Date received (approx.) ____ / _____
☐ Tdap (Tetanus, Diphtheria and Pertussis) vaccine	Date received (approx.) ____ / _____
☐ Meningococcal vaccine	Date received (approx.) ____ / _____
☐ Pneumococcal vaccine	Date received (approx.) ____ / _____
☐ Chickenpox vaccine	Date received (approx.) ____ / _____
☐ Shingles vaccine	Date received (approx.) ____ / _____