

# PERSONAL HEALTH HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Reason for Visit \_\_\_\_\_

Current Health Concerns: \_\_\_\_\_

## Reproductive History:

**Menstrual History:** Last menstrual period \_\_\_\_\_  
 Age at onset \_\_\_\_\_ Age at menopause \_\_\_\_\_  
 Amount of flow:  heavy  medium  light # days of flow: \_\_\_\_\_  
 Are your periods  regular  irregular # days from one cycle to the next: \_\_\_\_\_  
 Pain/cramps:  none  mild  moderate  severe  
 Bleeding between periods?  Yes  No

## **Gynecological /Endocrine History:**

Last Pap test: \_\_\_\_\_ Results: \_\_\_\_\_  
 Last Mammogram: \_\_\_\_\_ Results: \_\_\_\_\_

Please check below any that apply to you:

- |  |   |
|--|---|
| <input type="checkbox"/> Gonorrhea                 | <input type="checkbox"/> Chlamydia                |
| <input type="checkbox"/> Genital herpes            | <input type="checkbox"/> Condyloma/venereal warts |
| <input type="checkbox"/> Pelvic infection          | <input type="checkbox"/> Painful intercourse      |
| <input type="checkbox"/> Breast discharge          | <input type="checkbox"/> Breast disease           |
| <input type="checkbox"/> Acne                      | <input type="checkbox"/> Excessive hair growth    |
| <input type="checkbox"/> Did your mother take DES? | <input type="checkbox"/> Douche                   |
| <input type="checkbox"/> Abnormal PAP              | <input type="checkbox"/> Vaginal lubricants       |
| <input type="checkbox"/> Abnormal mammogram        |   |

## **Obstetrical history:**

# of pregnancies \_\_\_\_\_ Full term deliveries \_\_\_\_\_ Premature births \_\_\_\_\_  
 Stillborn \_\_\_\_\_ Miscarriages \_\_\_\_\_ Elective terminations \_\_\_\_\_

Date of Birth	Sex	Birth Weigh	Duration of Pregnancy	Vaginal Delivery/ C-Section	Where Delivered	Present Health

**NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Birth Control:** (If this section does not apply to you, please skip)

Current method: \_\_\_\_\_ Are you satisfied with your current method? \_ yes \_ no

Check those methods that you have used:

- none     abstinence     rhythm     diaphragm/cervical cap     condoms     contraceptive foam      
birth control pills/patch/vaginal ring     IUD     vasectomy     tubal ligation

**Past Medical History**

**Medical Illnesses:** Have you ever had any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Thyroid disease           |
| <input type="checkbox"/> Epilepsy/seizure disorders   | <input type="checkbox"/> Migraines            | <input type="checkbox"/> Asthma/lung disease       |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Blood clots          | <input type="checkbox"/> Kidney disease            |
| <input type="checkbox"/> Stroke                       | <input type="checkbox"/> Intestinal disorders | <input type="checkbox"/> Gall bladder disease      |
| <input type="checkbox"/> Gastric ulcer/gastric reflux | <input type="checkbox"/> HIV                  | <input type="checkbox"/> Injuries/accidents: _____ |
| <input type="checkbox"/> Hepatitis                    | <input type="checkbox"/> Rheumatic fever      | _____  |
| <input type="checkbox"/> Heart murmur                 |   |  |

**Allergies:**    \_ Yes                    \_ No

**Allergy Type:** \_\_\_\_\_

**Current medications that you are taking including any herbal preparations:** \_\_\_\_\_

**Previous Hospitalization(s) and Date(s):** \_\_\_\_\_

**Previous Surgeries and Dates:** \_\_\_\_\_

**Please check the box next to any of the following that you have had:**

- |   |  |
|---|--|
| <input type="checkbox"/> Eye disease/impaired sight   | <input type="checkbox"/> Involuntary loss of urine               |
| <input type="checkbox"/> Impaired hearing             | <input type="checkbox"/> Anemia                                  |
| <input type="checkbox"/> Sinus condition              | <input type="checkbox"/> History of sexually transmitted disease |
| <input type="checkbox"/> Dizziness/fainting spells    | <input type="checkbox"/> Increased facial hair                   |
| <input type="checkbox"/> Seizures/convulsions         | <input type="checkbox"/> Swelling of hands/feet                  |
| <input type="checkbox"/> Paralysis                    | <input type="checkbox"/> Varicose veins                          |
| <input type="checkbox"/> Frequent or severe headaches | <input type="checkbox"/> Fatigue or weakness                     |
| <input type="checkbox"/> Depression/anxiety           | <input type="checkbox"/> Kidney disease/kidney stones            |
| <input type="checkbox"/> Thyroid problems             | <input type="checkbox"/> Bladder problems, infection             |
| <input type="checkbox"/> Skin disorders               | <input type="checkbox"/> Frequent heartburn/stomach ulcers       |
| <input type="checkbox"/> Chronic/frequent cough       | <input type="checkbox"/> Liver or gall bladder disease           |
| <input type="checkbox"/> Chest pain                   | <input type="checkbox"/> Colitis or bowel disease                |
| <input type="checkbox"/> Heart palpitations           | <input type="checkbox"/> Rectal bleeding, hemorrhoids            |
| <input type="checkbox"/> Shortness of breath          | <input type="checkbox"/> Constipation, diarrhea                  |

**NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Social History:**

Sleep patterns: \_\_\_\_\_ hrs/day Do you:  have difficulty falling asleep  staying asleep

Exercise patterns: Type(s) \_\_\_\_\_ hrs/wk \_\_\_\_\_

Leisure activities: \_\_\_\_\_

Diet/Usual caloric intake: \_\_\_\_\_

Have you had a  recent weight loss  recent weight gain If so, how many lbs. \_\_\_\_\_

Do you smoke?  yes  never If yes, for how long? \_\_\_\_\_ How much? \_\_\_\_\_  
 quit How long ago? \_\_\_\_\_

Do you drink alcohol?  yes  never If yes, for how long? \_\_\_\_\_ How much? \_\_\_\_\_  
 quit How long ago? \_\_\_\_\_

Do you drink caffeine?  yes  never If yes, for how long? \_\_\_\_\_ How much? \_\_\_\_\_  
 quit How long ago? \_\_\_\_\_

Do you use recreational drugs?  yes  never If yes, for how long? \_\_\_\_\_ How much? \_\_\_\_\_  
 quit How long ago? \_\_\_\_\_

History of physical abuse  yes  no History of sexual abuse  yes  no

**Psychosocial:**

Sexual Orientation  heterosexual  lesbian  bi-sexual

Have there been any major changes in your life recently?  yes  no If yes, please explain:  
\_\_\_\_\_

Do you feel that you deal with stress effectively?  yes  no If no, please explain:  
\_\_\_\_\_

Is religion important in your life?  yes  no

**NAME:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**Family History:**

Relative:	Age if living	Age @ time Death	Medical History/Cause of Death
MOTHER	_____	_____	_____
FATHER	_____	_____	_____
SISTER	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____
BROTHER	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____

Has anyone else in your family had any of the following? If so, indicate who:

- |   |   |
|---|---|
| <input type="checkbox"/> Diabetes_____            | <input type="checkbox"/> Cancer_____                |
| <input type="checkbox"/> Heart disease_____       | <input type="checkbox"/> High blood pressure_____   |
| <input type="checkbox"/> Stroke_____              | <input type="checkbox"/> Seizures/epilepsy_____     |
| <input type="checkbox"/> Cystic fibrosis_____     | <input type="checkbox"/> Tay Sachs_____             |
| <input type="checkbox"/> Sickle cell anemia_____  | <input type="checkbox"/> Down's Syndrome_____       |
| <input type="checkbox"/> Early menopause_____     | <input type="checkbox"/> Recurrent miscarriage_____ |
| <input type="checkbox"/> Endometriosis_____       | <input type="checkbox"/> Ovarian cancer_____        |
| <input type="checkbox"/> Breast cancer_____       | <input type="checkbox"/> Thyroid disease_____       |
| <input type="checkbox"/> Psychiatric disease_____ | <input type="checkbox"/> Other_____                 |

**Husband/partner history:**

Has anyone in your partner's family had any of the following? If so, indicate who:

- |   |   |
|---|---|
| <input type="checkbox"/> Diabetes_____            | <input type="checkbox"/> Cancer_____                |
| <input type="checkbox"/> Heart disease_____       | <input type="checkbox"/> High blood pressure_____   |
| <input type="checkbox"/> Stroke_____              | <input type="checkbox"/> Seizures/epilepsy_____     |
| <input type="checkbox"/> Cystic fibrosis_____     | <input type="checkbox"/> Tay Sachs_____             |
| <input type="checkbox"/> Sickle cell anemia_____  | <input type="checkbox"/> Down's Syndrome_____       |
| <input type="checkbox"/> Early menopause_____     | <input type="checkbox"/> Recurrent miscarriage_____ |
| <input type="checkbox"/> Endometriosis_____       | <input type="checkbox"/> Ovarian cancer_____        |
| <input type="checkbox"/> Breast cancer_____       | <input type="checkbox"/> Thyroid disease_____       |
| <input type="checkbox"/> Psychiatric disease_____ | <input type="checkbox"/> Other_____                 |

Number of siblings: Sisters \_\_\_\_\_ Brothers \_\_\_\_\_

**Check those items that you would like further information:**

- Smoking cessation
- Nutrition counseling
- Massage therapy
- Acupuncture
- Psychological counseling
- Preconception counseling
- Fertility evaluation
- Menopause management
- Other: \_\_\_\_\_