Patient Health History

Name: _____ **Date:** _____

Medical Problems: _____

Surgeries Procedures & Date: _____

Medication: _____

Allergies: _____

Vaccines & Date: _____

Past Medical History: please answer yes or no

Anemia _____ **Heart Condition** _____

Anesthesia complications _____ **Heart Disease** _____

Anxiety _____ **Hepatitis** _____

Arthritis _____ **High Blood Pressure** _____

Asthma _____ **Hypertension** _____

Birth Defect or Inherited Disease _____ **Infertility** _____

Breast Cancer _____ **Kidney Disease** _____

Breast Problems _____ **Kidney or Bladder Problems** _____

Cancer _____ **Lung Disease** _____

Depression _____ **Ovarian Cancer** _____

Diabetes _____ **Psychiatric Illness** _____

Endometriosis _____ **Thyroid Problems** _____

GI Problems _____ **Varicosities** _____

Headaches or Migraines _____

Social History
Smoking Status Y/N Smoking-How much? _____
Tobacco-years of use_____

Occupation_____
Education_____

Marital status Married/Single/Divorced/Separated

Sexual orientation_____ Sexually active? Y/N

Alcohol intake_____
Illicit drugs_____

Performs monthly self-breast exam Y/N
Do you have a medical living will? Y/N

Family History

Relation	Problem	Onset Age	Age of Death

GYN History
Duration of Flow (days) _____

Frequency of Cycle (Q days) _____

Menses Monthly Y/N

Flow (heavy) (normal) (mild)

Age at First Child _____

Age at 1st Period _____

***Current Birth Control Method* _____**

On BCP's at Conception? Y/N

If Post Menopausal, Age at Menopause _____

First Date of Last Period _____