PERSONAL HEALTH HISTORY

PATIENT NAME: ____ DOB: ______/______/_______

REASON FOR VISIT TODAY: ____

IF PREGNANT, HAVE YOU BEEN SEEN BY ANOTHER PHYSICIAN: ________ IF SO, WHOM: ____________________

ANY KNOWN DRUG ALLERGIES: _____ NO _____YES IF YES, PLEASE LIST: ____________________

DATE OF LAST PAP SMEAR: ________/________/________ DATE OF LAST MAMMOGRAM: ______/ ______/ ______

DATE OF LAST BONE DENSITY: ________/_______/________ DATE OF LAST COLONOSCOPY: ______/______/_______

DID YOU RECEIVE THE GARDASIL INJECTIONS? ____ NO ____ YES DATE COMPLETED: _______/_______/________

CURRENT MEDICATIONS _____ NOT TAKING ANY MEDICATIONS

DRUG NAME	DOSAGE	PRESCRIBING PHYSICIAN

PLEASE MARK ANY CONDITION YOU HAVE OR HAD IN THE PAST ______ DOES NOT APPLY

	ANEMIA		RECURRENT URINARY TRACT INFECTIONS
	ASTHMA		SEXUALLY TRANSMITTED DISEASES
	CANCER		HIV/AIDS
	DIABETES		THYROID DISORDER
	EPILEPSY		DEPRESSION
	HEART DISEASE		BOWEL DISEASE
	HIGH BLOOD PRESSURE		OTHER____________________

SURGICAL HISTORY _______ NO PRIOR SURGERIES

DATE OF SURGERY	TYPE OF SURGERY

SOCIAL HISTORY

ALCOHOL USE: ______NO _____YES IF YES, HOW OFTEN AND WHAT TYPE: ____________________

DO YOU SMOKE CIGARETTES? _____ NO ____ YES IF YES, HOW MANY PACKS PER DAY? ____________________

AGE STARTED SMOKING: ______________ IF FORMER SMOKER, WHEN DID YOU QUIT? ____________________

PLEASE LIST ANY ILLICIT OR RECREATIONAL DRUG USE (COCAINE, MARIJUANA, ETC) ____________________

DO YOU EXERCISE? ______YES ______NO WHAT TYPE AND HOW OFTEN? ____________________

PLEASE COMPLETE THE ENTIRE FORM.

MENSTRUAL HISTORY

LAST NORMAL MENSTRUAL PERIOD (FIRST DAY): _________/ __________/____________ AGE PERIODS BEGAN: _______________
LENGTH OF PERIODS (NUMBER OF DAYS BLEEDING): __________ IS FLOW _____LIGHT _____MEDIUM ____HEAVY
IRREGULAR BLEEDING: _____YES ____NO CLOTS: _____YES _____NO NUMBER OF DAYS BETWEEN CYCLES: __________
HAVE YOU EVER HAD AN ABNORMAL PAP TEST: _____YES _____NO IF YES, WHEN: ____
PRESENT METHOD OF BIRTH CONTROL: ____
AGE OF MENOPAUSE: _______________ CURRENTLY ON HORMONES: _______YES ______NO

OBSTETRIC HISTORY ______ NO PRIOR PREGNANCIES

NUMBER OF PREGNANCIES: ________ NUMBER OF LIVING CHILDREN: ________ NUMBER OF ABORTIONS: _________
NUMBER OF MISCARRIAGES: ________ NUMBER OF TUBAL PREGNANCIES: ________
NUMBER OF FULL TERM BIRTHS: ________ NUMBER OF PREMATURE BIRTHS (<37 WEEKS): ________

DATE OF BIRTH	BABY'S WEIGHT AT BIRTH	BABY'S SEX	WEEKS PREGNANT	VAGINAL OR C-SECTION	HOSPITAL

FAMILY HISTORY _______ DOES NOT APPLY

PLEASE CHECK ALL THAT APPLY

	ILLNESS	*WHICH RELATIVE*	*AGE OF ONSET*
	DIABETES		
	HEART DISEASE		
	HIGH BLOOD PRESSURE		
	GENETIC OR INHERITED DISORDER		
	OSTEOPOROSIS		
	STROKE		
	THYROID DISEASE		
	OTHER _____________________________		
	BREAST CANCER		
	COLON CANCER		
	OVARIAN		
	GYNECOLOGIC CANCER		
	OTHER CANCER______________________		

MOTHER: _____ LIVING ______ DECEASED/CAUSE ____ AGE: ______________

FATHER: _____ LIVING _______ DECEASED/CAUSE ____ AGE: ______________