



INITIAL PATIENT HISTORY FORM

Please complete both sides of this form before seeing the provider. If you have any questions, please ask for assistance.

Patient's Name _____ Age _____ DOB _____

Religion _____ Marital Status _____

Social Security Number _____ Primary Care Doctor _____

MEDICAL HISTORY

1. Reason for appointment _____

2. Have you ever had any of the following conditions? (Self) YES NO

- a. Diabetes ... b. High Blood Pressure ... c. Epilepsy or Seizures ... d. Frequent or Severe Headaches ... e. Sickle Cell ... f. Heart Disease/Heart Attack ... g. Stroke ... h. Cancer ...

Has any family member had any of the following? (M, F, GM, GF, etc.) YES NO

- Who? ... Who? ... Who? ... Who? ... Who? ... Who? ... Who? ... Who? ...

3. Have you ever had any of the following conditions? If you answer YES to any, EXPLAIN YES NO

- a. Thyroid disease ... b. Breast mass (lumps) or discharge ... c. Asthma ... d. TB or any other type of lung condition ... e. Heart murmurs ... f. Rheumatic Fever ... g. Stomach/intestinal problems ... h. Hepatitis/mono or liver problems ... i. Gall bladder disease ... j. Chronic bladder or kidney infections ... k. VD or STD (gonorrhea, syphilis, herpes, clap) ... l. Frequent vaginal infections ... m. Infection of the uterus, tubes, ovaries ... n. Tumors ... o. Blood clots in veins ... p. Varicose veins ... q. Anemia ... r. Rubella (german measles/3 day measles) ... s. Immunizations (vaccinations) ... t. Mental/emotional problems ... u. Other ...

Allergies: are you allergic to anything (medication, food, other)?

Please list any type of medication that you are taking (prescribed, herbal, over the counter)

Do you use any of the following? If so, how much?

Cigarettes _____

Alcohol _____

Drugs _____

SURGERY HISTORY

Please list any surgeries that you may have had and the dates.

PREGNANCY HISTORY:

Have you ever been pregnant? YES NO If yes, please complete the rest of the following questions:

_____ a. Total number of times pregnant including this one.

_____ b. Number of live births

_____ c. Number of miscarriages

_____ d. Number of elective abortions

_____ e. Number of vaginal births

_____ f. Number of C-Sections

_____ g. Number of Living Children

_____ h. Age at first pregnancy

Any complications with the delivery or pregnancy _____

MENSTRUAL HISTORY:

First date of last period _____

Age when you started your periods _____

Number of days from one period to the next _____

Number of days your periods last _____

Amount of flow: Heavy _____ Medium _____ Light _____

Cramping: None _____ Mild _____ Moderate _____ Severe _____

Do you have any of the following?

_____ a. Cramps

_____ e. Vaginal sores

_____ b. Discomfort before periods

_____ f. Spotting after intercourse

_____ c. Abnormal Vaginal Discharge

_____ g. Painful intercourse

_____ d. Vaginal odor, itching, swelling, burning

Have you ever had a mammogram? _____

Date of last PAP smear? _____ Normal _____ Abnormal _____ Where? _____

If abnormal, what type of treatment was used? _____

Do you use feminine hygiene products? _____

CONTRACEPTIVE HISTORY

What type of contraception do you use? _____

How long have you used this method? _____

What method do you want to use now? _____

Are you trying to get pregnant? YES NO If yes, how long? _____

How many partners have you had? _____

How old were you when you started having sex? _____

Please check all methods that you have used for contraception:

- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Rhythm | <input type="checkbox"/> Tubes tied |
| <input type="checkbox"/> Oral | <input type="checkbox"/> Natural Family Planning | |
| <input type="checkbox"/> IUD | <input type="checkbox"/> Injection | |
| <input type="checkbox"/> Condoms | <input type="checkbox"/> Abstinence | |
| <input type="checkbox"/> Diaphragm | <input type="checkbox"/> Luck | |
| <input type="checkbox"/> Foam, jelly, cream | <input type="checkbox"/> Vasectomy | |

Signature

Date

Physician Signature

Date