Date_____ **Health History** Form Updated on _____

Patient Name_____ DOB_____ Ht_____ Wt_____

Allergies/Adverse Drug Reactions Check here if **None:**_____		
Medications (including birth control, herbals, vitamins, dietary supplements and over the counter) Check here if **None:**_____		
Last Tetanus:	Hep B:	Gardasil:

Pregnancies/Miscarriages		**G:**		**P:**
Date	Weeks	Birth Wt/Sex	Vag/C-sxn	Complications/Problems

Gynecologic Health History

When was your last period?_____ At what age did you start periods?_____ When was your last pap smear?_____
Have you ever had an abnormal pap smear? Yes_____ No_____ If yes, when was the abnormal pap smear?_____
What was the abnormality?_____ What kind of treatment did you have?_____
When was your last mammogram?_____ Have you ever had an abnormal mammogram? Yes_____No_____ If yes, when?_____
Contraceptive History- what and how long?
Birth Control Pills_____ Depo Provera_____
IUD: Type_____ Dates_____ Other:_____
Sexually Transmitted Diseases/Dates
Chlamydia_____ Gonorrhea_____ HPV/Condyloma_____ Herpes_____PID_____

Surgical History

Procedure	**Date**	**Procedure**	**Date**
Hysterectomy		Abdominal Surgery	
Tubal Ligation		Gallbladder Removal	
Other GYN Surgery		Appendectomy	
Breast Surgery		Other:	

Social History

The following questions are very important and strictly confidential. Please answer them accurately.

Single/Married/Divorced/Other_____ Occupation_____
Have you ever smoked? Yes_____ No_____ If yes, how many packs a day do you smoke now?_____
How many years have/did you smoke?_____ If applicable, when did you stop smoking?_____
Other Tobacco use?_____
Do you drink Alcohol? Yes_____ No_____ How much?_____ How often?_____
Do you use drugs? Yes_____ No_____ Ever_____ What kind_____ How often_____
Exercise: Never/rarely/regularly

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Past and Present Health Conditions					
Disease	**Yes**	**No**	**Disease**	**Yes**	**No**
Irregular Heart Beat			Kidney Disease (Type)		
Congestive Heart Failure			Kidney Stones		
Heart Attack			Gout/Arthritis		
Heart Murmur			Skin Disease (Type)		
Rheumatic Fever			Stroke		
High Cholesterol			Epilepsy/Seizures		
High Blood Pressure			Diabetes/High Blood Sugar		
Asthma/Breathing Problems			Thyroid Problems (too low/high)		
Blot clot in the lung/leg			Anemia/Low blood		
Gallstones			Bleeding Problems (Type)		
Liver Disease (Type)			Blood Transfusion		
Ulcers in bowel/stomach			Cancer (Type)		
Bleeding from Bowels			Anxiety/Depression		
Other:			Other:		

Family History							
Disease	**Relationship**	**Yes**	**No**	**Disease**	**Relationship**	**Yes**	**No**
Heart Attack				Stroke			
High Blood Pressure				Bleeding/Clotting Problems			
High Cholesterol				Diabetes/High Blood Sugar			
Asthma				Thyroid Problems			
Liver Disease				Breast Cancer			
Kidney Disease				Ovarian Cancer			
Gout/Arthritis				Uterine Cancer			
Osteoporosis				Colon Cancer			
Anxiety/Depression				Other Cancers:			
Other:				Other:			

Notes: For Office Use Only

The information above is current and correct to the best of my knowledge.

_____

Patient Signature/Date