

PATIENT HISTORY FORM

Name: _____

Date: _____

Occupation: _____

DOB: _____

What drugs are you allergic to? _____

Are you Latex allergic? ___ Yes ___ No

Your Medical History:

Do YOU have any of the following?

Osteoporosis	___	Breast Disease	___	Mental Health Problems	___
Asthma/Lung disease	___	High Blood Pressure	___	Cancer	___
Headaches	___	Heart Disease	___	Thyroid Disease	___
Diabetes	___	Stomach problems	___	Bleeding Easily	___
Blood Transfusion	___	Liver problems	___	Blood Clots	___
Stroke	___	Kidney Disease/stones	___	High Cholesterol	___

What other diseases do you have?

Family History:

Do any of your close family members (father, mother, sister, brother, aunts, or uncles) have any of the following?
(exclude grandparents and cousins):

Diabetes	___	Osteoporosis	___	Blood clots	___
Heart Disease	___	Mental Illness	___	Uterus cancer	___
High Blood Pressure	___	Alzheimers	___	Ovary cancer	___
High Cholesterol	___	Colon Cancer	___	Breast cancer	___

Any serious family diseases not listed above? (Describe)

Habits/Risks:

Do you drink alcohol? _____ How much? _____

Do you smoke? _____ How much? _____

Do you exercise? _____ Describe: _____

When was your last: Pap smear: _____ Mammogram: _____

Cholesterol test: _____ Bone density: _____

Do you: Do monthly breast exams ___ Yes ___ No Use seat belts regularly ___ Yes ___ No

Do you have issues around food? _____

Who do you see for other health care?

Primary Care : _____

Chiropractor: _____

Massage: _____

Acupuncture: _____

Counseling: _____

Naturopath: _____

Other: _____

What medicine/supplements/vitamins do you take?

Please complete next page also (over)

Surgery History

List the surgeries you have had and the year (major and outpatient surgeries)

Obstetric/Gynecology History:

Have you ever had an abnormal pap? ___ Yes ___ No

-what was done about it? _____

Have you had any of (circle):

GC, Chlamydia, Genital warts, Herpes, HIV, "PID", endometriosis, infertility, fibroids, ovarian cysts, DES exposure, or other gyn problems? Please describe: _____

Do you have problems with urination?

___ bladder infections ___ leaking easily ___ getting up at night ___ urinating frequently
___ trouble emptying your bladder completely

Have you ever been pregnant? ___ Yes ___ No

If yes, please complete this section.

Children's Names/Ages: _____

How many times have you been pregnant? _____

How many miscarriages? _____

How many terminations? _____

How many vaginal births? _____

Any stillbirths? _____

Multiple births? _____

How many C/sections? _____

Any pregnancy complications? _____

Menstrual History:

Age of first period: _____

Age of last period (if applicable): _____

Menstrual cycle.....

how many days apart are your "periods"? _____ do cramps bother you? _____

how many days do you bleed? _____

describe problems with your "periods": _____

Before your menses, do you get: ___ moody ___ bloated ___ acne ___ sore breasts

Is your sexual partner a ___ man or a ___ woman?

Do you use contraception? ___ pill ___ condom ___ Depo Provera ___ diaphragm

___ withdrawal ___ spermicide ___ IUD ___ tubal ___ vasectomy

Describe what contraception problems you have had: _____

What hormones have you used before, if any?: _____

Any other medical history information we didn't ask?

(office use only..... ___ history form reviewed by Dr. Ledbetter date _____, _____)