PATIENT MEDICAL HISTORY FORM

Name________________________________ Preferred Name_________________________ Date of Birth_______________

☐Single ☐Married ☐Divorced ☐Separated ☐Widowed Referring Dr _________________ Primary Dr__________________

MEDICAL HISTORY **Have you EVER had any of the following?**

☐ Anemia
☐ Heart Disease/attack
☐ High Blood Pressure
☐ Stroke
☐ High Cholesterol
☐ Mitral Valve Prolapse
☐ Blood Clots in Lungs/Legs
☐
☐ Lung Disease
☐ Asthma
☐ Liver Disease/Hepatitis
☐ Kidney Disease/Infection
☐ Bladder Infections
☐ Pelvic Infections
☐ Arthritis
☐ Bleeding Problems
☐ Seizures/Epilepsy
☐ Headaches/Migraines
☐ Depression/Anxiety
☐ Diabetes
☐ Drug or Alcohol Problem
☐ Gall Bladder Problems
☐ Pneumonia
☐ Tuberculosis
☐ Thyroid Problem
☐ Sickle Cell
☐ Genetic Condition
☐ Blood Transfusion
☐ Cancer__________________________

MEDICATIONS List ALL medications you are currently taking, include over-the counter, vitamins, herbal remedies:

ALLERGIES **List ALL allergies to medications/latex and the reaction:**________________________________

SURGERIES **List ALL surgeries with dates:**_______

GYN Age of first period_______ First Day of last period_______ Menstrual Cycle : every______days lasting______days

Menstrual Cycles (Periods) are: ☐ Regular ☐ Irregular ☐ Painful ☐ Not really bothersome

Flow is: ☐ Light ☐ Light to moderate ☐ Moderate ☐ Moderate to Heavy ☐ Very Heavy

On heaviest day of period, I soak a pad / tampon / both every ______________hour (s).

Are you sexually active? ☐Yes ☐No ☐Never had sex Number of lifetime partners______________________

New Partners? ☐Yes ☐No Length of time w/ current partner ______________________________

Birth Control Method: ☐None ☐Withdrawal ☐Condom ☐Pill ☐Patch ☐Vaginal Ring Implanon DepoProvera

IUD (type)______________ Tubal Ligation Partner w/ Vasectomy Natural Family Planning Other___________

Have you ever had a sexually transmitted disease? ☐Never had any ☐Chlamydia ☐Gonorrhea

☐Herpes Type 1 (oral) Type 2 (genital) ☐HPV (Human Papilloma Virus) ☐Condyloma ☐Syphilis

☐Trichomonas ☐ HIV ☐ Hepatitis B ☐ Hepatitis C

Have you ever had any of the following? ☐Ovarian Cysts ☐Uterine Fibroids ☐Endometriosis

☐Fibrocystic Breasts ☐Cancer (type and date)____

Last Pap Smear (date)____________☐Never had one ☐Normal ☐Abnormal______________________________

Any treatment for an abnormal pap smear? ☐None ☐Colposcopy ☐Cryosurgery ☐LEEP/Conization ☐Laser

Date of Last Mammogram_______________ ☐Never had one ☐Normal ☐Abnormal_________________________

Treatment for an abnormal mammogram?/Biopsies?(date/details)_____________________________________

Date of last Bone Density(DEXA scan) __________ ☐ Never had one ☐Normal ☐Osteopenia ☐Osteoporosis

Date of last Colonoscopy ____________Results_________________ ☐Other/Explanations______________________

Immunizations/date: Tdap(tetanus)___________ MMR___________ Hepatitis A____________ Hepatitis B____________

HPV (Gardasil) ___________ Pneumonia____________ Influenza________ ________ ________ ________ _______

Other____

OBSTETRICAL HISTORY Check here if you have never been pregnant

Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal) and abortions.

Year	M/F	Weight	Type of Delivery	Problems (preterm labor, diabetes, high blood pressure)	Name / Age

Comments____

FAMILY HISTORY Please list any close relatives with a history of the following:

Relative/Age at diagnosis Relative/Age at diagnosis

High blood pressure____________________ Diabetes ____________________

Stroke____________________ Colon Cancer____________________

Blood clots in lungs/legs____________________ Breast Cancer____________________

Heart Disease____________________ Uterine Cancer____________________

Genetic Disorders____________________ Ovarian Cancer____________________

Bleeding Problems____________________Other____________________

Comments____

SOCIAL HISTORY

Where are you from initially?____________________ ______What year did you move to Alaska?__________

Alcohol use	No Yes	Type & How many drinks per day/week/month?____________________
Tobacco use	No Yes	Packs per day/wk/mo?__________Started at age__________ Quit at age__________
Street Drugs	No Yes	Type and Frequency____________________
Caffeine	No Yes	Type and Frequency____________________

REVIEW OF SYSTEMS Do you currently have any of the following?

		Comments			Comments
Generally Healthy	No Yes		Frequent Urination	No Yes	
Recent 25 lb weight change	No Yes		Pain with Urination	No Yes	
Fever	No Yes		Incontinence	No Yes	
Chest Pain	No Yes		Urinary Urgency	No Yes	
Shortness of Breath	No Yes		Bladder infection	No Yes	
Chronic Cough	No Yes		Stomach pain	No Yes	
Heartburn	No Yes		Pelvic pain	No Yes	
Thyroid Disease	No Yes		Painful intercourse	No Yes	
Breast Lumps	No Yes		Vaginal Discharge	No Yes	
Depression/Anxiety	No Yes		Blood in stools	No Yes	

Other/Comments____

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Patient Signature____________________ Today's Date__________

Clinician's Signature____________________ Review Date__________

Annual Review Date/Initials __________ __________ __________ __________ __________ __________