**PAST MEDICAL HISTORY**

In order to assist us in providing the best care possible, please fill out the following medical history to the best of your ability.

**Major Events, Hospitalizations, Surgeries:**

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| --- | --- | --- |
| Reason  | Year | Treatment |
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**Allergies:**

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| Please list any medication, food or environmental allergies, year of onset and reaction. |
| Allergy | Year | Reaction |
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**Ongoing Medical Problems:**

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| Please describe any ongoing medical problems, the year it started, the treating Doctor and any medications you are taking for it. |
| Ongoing Medical | Year | Treating Doctor | Medication(s) |
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**Current Medications:**

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| --- | --- | --- | --- | --- |
| **Name** | **Dose** | **Frequency**  | **Prescribed by:** | **Reason:** |
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| **Family Medical History** : Please provide as much information as possible.  |
| **Mother Full Name** | Year of Birth: | Alive: Yes No | Health Issues: |
| Year of Death: | Cause of Death: |
| **Father Full Name**  | Year of Birth: | Alive: Yes No | Health Issues: |
| Year of Death: | Cause of Death: |
| **Siblings:** | Name / Sex: | Year of Birth: | Health Status |
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| **Children:** | Name: | Year of Birth: | Health Status: |
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**Genetic History:** Ethnic Background: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Partner’s Ethnic Background: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has anyone in your or your partner’s family had any of the following? If so please include which family member(s).**

Autism \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Muscular Dystrophy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hemophilia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Open spine (Bifida) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cystic Fibrosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sickle Cell Anemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Down Syndrome \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thalassemia \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Huntington’s Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unexplained fetal loss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Congenital heart disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Menstrual History:** last menstrual period \_\_\_\_\_\_\_\_\_\_\_\_\_ Age (yrs.) at 1st period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My period occurs every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and last for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ days.

**Please circle:** Heavy periods : No Yes Painful periods: No Yes Irregular Bleeding: No Yes

**Gynecological History:** Last Pap Smear: \_\_\_\_\_\_\_ Abnormal Pap: No Yes Year \_\_\_\_\_\_\_\_ Provider / treatment received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any of the following conditions? (Please check all that apply).**

Gonorrhea \_\_\_ Chlamydia \_\_\_ Herpes \_\_\_ Trichomoniasis \_\_\_ Genital warts/ HPV \_\_\_ Endometriosis \_\_\_ None \_\_\_\_

**If so, when and how was it treated?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any of the following conditions? (Please check all that apply).**

Uterine Fibroids \_\_\_\_ Infertility \_\_\_\_ Ovarian Cyst \_\_\_\_ Breast disease/ Biopsy \_\_\_\_\_ Endometriosis \_\_\_\_\_ None \_\_\_\_

**If so, when and how it was treated?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you used hormone therapy in the past? No \_\_\_ Yes \_\_\_ for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contraceptive:**

Sexually Active: No: \_\_\_ Yes: \_\_\_ Medical issues pertaining to sexual activity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Method of preventing pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with this method: Yes No Dissatisfied because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous methods you have used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have questions about family planning that you wish to discuss? Not at this time \_\_ Yes \_\_

Are you planning a pregnancy in your future? No Yes

**Pregnancy History: # of** \_\_\_\_\_ vaginal \_\_\_\_ C-section \_\_\_\_\_ Miscarriages \_\_\_\_ Abortions \_\_\_\_\_ Ectopic \_\_\_\_

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| --- | --- | --- | --- | --- | --- |
| **Date** | **Delivery Type** | **Gestation** | **Birth Weight** | **Gender/ Name** | **Complications** |
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**Preventative Care:**

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| Please list any preventative health care services you have had in the past, the date and any comments you may consider important for us to know |
| Service | Date | comments |
| DEXA Scan: Yes No |  |  |
| PAP: Yes No  |  |  |
| Colonoscopy: Yes No |  |  |
| Mammo: Yes No |  |  |
| Flu Shots/ Immunizations:  |  |  |
| EKG: |  |  |

**Social History:** Education/Last year of school completed: \_\_\_\_\_\_\_\_\_\_\_\_\_ Religious Preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Currently Employed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ x \_\_\_\_\_\_\_years

I retired in (year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ From: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Single: \_\_\_\_\_ Divorced: \_\_\_\_ Widowed since: \_\_\_\_ Living with partner: \_\_\_\_\_ Married: \_\_\_\_\_ x \_\_\_\_\_ years,

Partner/Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutritional History:**

Diet includes fruit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ times per week. Diet includes Leafy green vegetables \_\_\_\_\_\_ times per week.

Diet includes fresh salad \_\_\_\_\_\_\_\_\_\_\_\_ times per week. Other vegetables \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ times per week.

Please estimate your usual weekly source of protein intake including: \_\_\_\_\_\_\_\_\_\_ legumes, \_\_\_\_\_\_\_\_\_\_ fish, \_\_\_\_\_\_\_\_\_\_ red meat, \_\_\_\_\_\_\_\_\_\_ chicken, \_\_\_\_\_\_\_\_\_\_ pork, \_\_\_\_\_\_\_\_\_\_eggs, \_\_\_\_\_\_\_\_\_\_dairy.

Fried foods are used \_\_\_\_\_\_\_\_\_\_\_\_\_\_ times per week.

Meal patterns includes (check all that apply): \_\_\_\_\_\_\_\_\_breakfast, \_\_\_\_\_\_\_\_\_\_ lunch, \_\_\_\_\_\_\_\_\_\_ dinner, \_\_\_\_\_\_\_\_\_\_ am snack, \_\_\_\_\_\_\_\_\_\_ pm snack, \_\_\_\_\_\_\_\_\_\_bedtime snack

Typical daily fluids includes (estimate amounts and type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prior or current drug use:**

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use alcoholic beverages: \_\_\_\_\_ no, \_\_\_\_\_ yes, approximately \_\_\_\_\_\_\_\_times per **(circle one)** week, month, year.

Do you currently use Tobacco Products: \_\_\_\_ no,\_\_\_ yes, approximately \_\_\_\_\_\_\_\_ times per **(circle one)** week, month.

Have you ever used Tobacco Products? \_\_\_\_ no \_\_\_\_ yes but stopped in \_\_\_\_\_\_\_\_

 History of \_\_\_\_\_\_\_ pack/day x \_\_\_\_years