Health History Form

Today's Date: ____________________

First Name: ________________ Last Name: ________________________ DOB: _____________ Age: _______________

Referred By: ________________________________ Primary Care Physician: ___________________________________

Reason For Visit: ____

Please check any of the following health conditions that apply to YOU
(Please Specify = Example: Umbilical Hernia, Cancer of the Colon)

Abnormal Pap ☐	Ovarian Cysts ☐	Fibroids ☐	Epilepsy ☐	Migraines ☐
Genital Herpes ☐	Heart Murmur ☐	Anxiety ☐	Lung Disease ☐	Liver Disease ☐
HIV ☐	Bladder Infections ☐	Heart Disease ☐	High Cholesterol ☐	Asthma ☐
Endometriosis ☐	Infertility ☐	Ulcer (specify) ☐	Thyroid Disease ☐	Breast Disease ☐
Hepatitis A, B, or C ☐	Diabetes I or II ☐	Acid Reflux (GERD) ☐	High Blood Pressure ☐	Mental Illness (specify) ☐
Vaginal Warts (HPV) ☐	Pelvic Infections ☐	Blood Clots (DVT) ☐	Hypothyroidism ☐	Bipolar Disorder ☐
Chlamydia ☐	Gonorrhea ☐	Depression ☐	Hyperthyroidism ☐	
CANCER (specify)		OTHER (specify)		

All Surgeries and Dates

Type of Surgery	Date	Type of Surgery	Date

Vaccines Past Year (ex Flu)	ALL Medications & Doses	ALL Medical Allergies & Reactions

Please check ALL medical conditions that apply to your FAMILY and list their relation to you.
(Example: Diabetes-Maternal Grandfather, Type II)

High Blood Pressure ☐	TWINS (Specify) ☐	Genetic Diseases ☐	Heart Disease ☐
Diabetes I or II ☐	High Cholesterol ☐	Birth Defects ☐	Heart Attacks ☐
Endometriosis ☐	Osteoporosis ☐	Mental Illness ☐	Stroke ☐
Blood Clots ☐	Hepatitis A, B or C ☐	Mental Retardation ☐	Alzheimer's ☐
Thyroid Disorder ☐	CANCER (Specify) ☐	OTHER (Specify) ☐	Pregnancy Complications ☐

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First Name: ______________ Last Name: ____________________ DOB: ___________

Are you currently sexually active? Y○ N○ # of Sexual Partners in the past year:

Any issues with intercourse? (Example: Pain, Dryness, Bleeding):

Do you get a period every month? Y○ N○

If you are Post-Menopausal, please list the age you stopped having a menstrual cycle:

Please list the 1st day of your last menstrual cycle (LMP): Age at onset of Menses:

Days bleeding Flow: Light ○ Medium ○ Heavy ○

Days in between menses Cramping: Mild ○ Moderate ○ Severe ○

Are you using anything to prevent pregnancy?
(Birth Control, Vasectomy, IUD, Nuvaring, Depo, Implant)

Last Pap Date: Result:

Last Mammogram Date: Result:

Bone Density Date: Result:

Marital Status: Single ○ Married ○ Engaged ○ Divorced ○ Domestic Partner ○

Do you perform self-breast exams? Y○ N○ If yes, How often?

Have you ever been a smoker? Y○ N○ If yes, How long?

Are you currently working? Y○ N○ If yes, Occupation:

Do you Exercise? Y○ N○ If yes, How often per week? Cardio ☐ Weights ☐ Yoga ☐

Do you eat a specific diet? Y○ N○ If yes, Specify:
(Example: Gluten Free, Vegan, Vegetarian, Lactose Intollerant)

Any recreational drug use? Y○ N○ If yes, what kind? How often?

Do you drink Alcohol? Y○ N○ If yes, how often? # of Drinks?

Do you drink Caffeine? Y○ N○ If yes, how often? # of Drinks?

Please List All pregnancies (Include Deliveries, Miscarriage , Ectopics and Terminations)

Date Mo/Day/Year	Length of Pregnancy (Weeks)	Birth Weight and Sex	C-Section or Vaginal	Anesthesia	Any complications with the pregnancy, labor, delivery or newborn