

# 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 \_\_\_\_\_, \_\_\_\_\_)