INITIAL HEALTH HISTORY

Welcome to our practice! In order to provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held in strictest confidence, and is only released with your written permission.

NAME: ______________________________ **DOB**: __________________ **Today's Date**: __________________

Local **PHARMACY** of choice (name/ location):

____

Primary Care Doctor: (kindly list other doctors currently caring for you)

____

____

ALLERGIES (list reaction):

____

____

MEDICAL CONDITIONS: (please list all medical problems you have had that required medications or hospitalization):

____

____

____

____

MEDICATIONS and how often you take them:

____

____

____

GYNECOLOGY HISTORY:

Age at very first menstrual period: ________ Date of most recent menses: ______________________________

Periods come every _____ days; They last _______ days; Comments: _____________________________________

Current method to avoid pregnancy: ____

If menopausal, age of menopause: _______ Hormone therapy? ____

OBSTETRICAL HISTORY:

Number of pregnancies, total: _______

Number delivered before 37 weeks gestation: _______ (vaginal: _______ by c-section: _______)

Number delivered after 37 weeks gestation: _______ (vaginal: _______ by c-section: _______)

Number of abortions: _____

Number of miscarriages: _____

Number of multiple births: _____

Number of children alive today: _____

Number of children adopted: _______

Complications of pregnancy or deliveries:

____

____

<u>FAMILY HISTORY:</u> (Please list the relative and the disease they carry/carried.)

____

____

____

____

<u>SOCIAL HISTORY</u>

Smoker: _____ Over a pack/day _____ under a pack/day _____ Quit _____ Never Have

For how many years did you smoke? _____

Occupation: ____

Exercise Level: ____

Diet – limitations or restrictions: ____

<u>Sexual History</u>:

Current Marital Status: ____________

Alcohol: _____ Never drink _____ Drink Rarely _____ Drink Socially _____Drink Nightly

Recreational Drug use: _______ Marijuana ________ Hx IV Drug Use _________ Other

Have you used prescription drugs other than for the person or purpose they were prescribed ________

Sexually Active: _____ Never ever (yet) ______ Not currently ________ Yes, I am

______ Male Partner ______ Female Partner ______ No preference

Have you been intimate with more than 5 partners in your lifetime: ________

Do you have an “Advance Directive” or “Living Will”? ____

Any history of child abuse, domestic violence or other abusive history? ______________________________

Do you feel safe in your own home? ____

SURGICAL HISTORY: (Please list all procedures you have had under anesthesia)

____

____

____

____

CURRENT CONCERNS: ____

____

____