Health History Intake Form- New/Annual Today's Date_____

Patient Name: _____First Date of Last Menstrual Period_____

What brings you to the office today?_____
Primary Care Physician:_____
Preferred pharmacy:_____Location:_____

Please circle Yes or No in response to the questions below

Past Medical History / Review of Systems: (Do any of the following apply to you)

Good general health lately?	No	Yes	Cough	No	Yes
Recent weight gain/loss	No	Yes	Asthma or wheezing	No	Yes
Heat or Cold intolerance	No	Yes	Shortness of breath	No	Yes
Excessive thirst or urination	No	Yes	Loss of appetite	No	Yes
Diabetes	No	Yes	Change in Bowel habits	No	Yes
Sinus problems	No	Yes	Blood in stool/black stool	No	Yes
Thyroid disease	No	Yes	Stomach Ulcer	No	Yes
Depression	No	Yes	Abdominal Pain	No	Yes
Anxiety	No	Yes	Bloating	No	Yes
Chest pain/heart attack	No	Yes	Liver Disease	No	Yes
High Blood Pressure	No	Yes	Difficulty Walking	No	Yes
High Cholesterol	No	Yes	Stroke or Head injury	No	Yes
Headaches or migraines	No	Yes	History of Blood Clot	No	Yes
Frequent Urination	No	Yes	(i.e. lung or leg)		
Leakage or dribbling of urine	No	Yes	Autoimmune disorders	No	Yes
Blood in urine/painful	No	Yes			

Past Medical History _____
_____

Surgical History _____
_____(Please list type of surgery and date)

Current Medications including dosage

_____ _____
_____ _____
_____ _____

Allergies to Medications NONE YES (specify) _____
_____

Latex allergy- No Yes
Food allergy- No Yes (specify)_____

<Please Complete Next page>

GYN History:

Vaginal Discharge	No	Yes	HPV/Gardasil vaccines	No	Yes
Sexual Difficulties	No	Yes	History of Endometriosis	No	Yes
History STD	No	Yes	History of Fibroids	No	Yes
History of Ovarian problems	No	Yes	History of PCOS	No	Yes
History of breast problem	No	Yes	Last Mammogram date & result:_____Normal/Abnormal		
or Breast surgery	No	Yes	Last Pap DATE/RESULT: _____Normal/Abnormal		
Painful menstrual periods	No	Yes	Age of start of menopause _____		
Irregular menstrual periods	No	Yes			
History of abnormal pap smears	No	Yes	**Genitourinary Symptoms (MonaLisa Touch Candidates)**:		
Current sexual relationship	No	Yes	Recurrent UTI	No	Yes
Age you became sexually active _____			Recurrent Bacterial or yeast infections	No	Yes
Total of sexual lifetime partners _____			Vaginal dryness	No	Yes
Sexual orientation _____			Pain with intercourse	No	Yes
Current method of contraception _____			Vulvar itching/burning/chronic rash	No	Yes
Age at first period _____			Dribbling/leaking urine	No	Yes
			Vulvar/Vaginal Atrophy	No	Yes
			Vaginal Laxity (loosening)	No	Yes

Pregnancy History

Total Number of pregnancies _____
Number of children _____
Preterm deliveries- deliveries occurring prior to 36 weeks _____
Miscarriages _____
Terminations _____
Term deliveries- deliveries after 37 weeks_____
Were any of your deliveries c-sections? YES or NO Reason for the c-section (if known)
_____
_____

Family Medical History: Relationship & disease or condition:
Mother: _____
Father : _____
Maternal Grandmother:_____
Maternal Grandfather: _____
Paternal Grandmother:_____
Paternal Grandfather:_____
Family Member:_____
Family Member:_____

Social History:
Do you smoke: Yes No How many PPD/years _____
Alcohol intake Status & History: _____
Illicit drug use:_____
Caffeine drinker: _____
Exercise status level: _____
Diet: regular, vegetarian, vegan, gluten free, non specific. _____
Marital Status: _____
History of domestic violence or sexual abuse:_____
Highest level of education:_____
Current Occupation: _____
Do you wear your seat belt?: Yes NO
Would you accept a blood transfusion in case of an emergency? Yes No
Vaccines in Florida? Yes No are they up to date?

Patient Signature_____ Date_____