Patient History Form

Patient Name: _____ ***Date of Birth:*** _____

Reason for Visit/ Complaints:
Current Pharmacy: (Address, Phone # and/or Fax#)

List Current Medications: (include dosage and Frequency)	
1.)	5.)
2.)	6.)
3.)	7.)
4.)	8.)

Circle those that pertain to Your Medical History:

Anxiety/Depression	Heart Disease	Epilepsy/Seizures	Stroke/ Blood Clots	STD's: which ones
Asthma	Cholesterol	HIV/AIDS	High Blood Pressure	
Anemia/ Blood Transfusion	Lung Disease	Bleeding Disorder	Cancer: which one	Other:
Arthritis/Joint Pains	Diabetes	Thyroids		

Surgical History: (Month/Year)	***Hospitalization: (Month/Year)***	***List any Allergies to medications:***

GYN History:

***Mo/Yr** of Last Pap smear?	***Were Results**: Normal/Abnormal/HPV (was Colposcopy done: yes/no)
***First Day of Last Menstrual Cycle:**	**Age of First Menstrual:**
***If in Menopause what age did it start:**	**Last Mammogram:**
***Average length of Cycle:**	**Last Breast Ultrasound:**
***Average length between cycles:**	**Last Pelvic Ultrasound:**
***Pain scale(Circle):** No Pain, Moderate Pain, Severe Pain	**Last Colonoscopy:**
***Flow Scale**: Light, Moderate, Heavy	**Last Bone Density:**

Sexual History:

Ever had Sex: Yes or No	**Contraceptives: (Circle)** None, Vasectomy,
Currently sexually active: Yes or No	Hysterectomy, Tubal –Ligation, Condoms,
Sexual Orientation: Heterosexual, Bisexual,	Birth Control (which one):
Homosexual	

OB History:

Ever Been Pregnant? Yes or No If yes, please fill out below:

Year	Vaginal or C-section	Premature or Full term	Complications: (circle one)	Miscarriages/ Abortions
			Yes/No	
			Yes/No	
			Yes/No	
			Yes/No	

Family Medical History: (Please list members Medical History)

Mother:	Father:
Maternal Grandmother:	Paternal Grandmother:
Maternal Grandfather:	Paternal Grandfather: