

PATIENT HISTORY

NAME: _____ DATE: _____ AGE: _____

ALLERGIES: _____

FAMILY HISTORY

Please indicate whether **immediate relatives** (parents, siblings, grandparents, aunts/uncles, cousins, or children) have or have died from any of the following:

Cancer:	Relationship	Age @ Diagnosis	Other family history	Relationship	Age @ Diagnosis
Breast	_____	_____	Hypertension/blood pressure	_____	_____
Ovarian	_____	_____	Mental illness	_____	_____
Uterine	_____	_____	Heart Attack	_____	_____
Colon	_____	_____	Diabetes	_____	_____
Other	_____	_____	Stroke	_____	_____
			Osteoporosis	_____	_____
			Alzheimer's Disease	_____	_____

PERSONAL HISTORY/HEALTH STATUS:

Mark "C" for current problem; Mark "P" for past problem:

BREAST	EXTREMITIES	NEURO & PSYCHIATRIC	GENERAL/ ENDOCRINE	INTESTINAL
Lump	Arthritis, joint pain	Frequent headaches	Back pain	Loss of appetite
Discharge	Cramps in legs	Fainting spells	Abnormal thirst	Abdominal swelling
Pain	Varicose veins	Dizzy spells	Unable to sleep	Black tarry stool
HEART/LUNG	Blood clots in legs	Depression or anxiety	Acne	Nausea or vomiting
Chronic cough	KIDNEY/BLADDER/ GENITALS	Suicidal thoughts	Unusual fatigue	Pain in abdomen
Shortness of breath		Albumin or sugar in urine	Skin changes	Gallbladder trouble
Night sweats		Blood or pus in urine	Abnormal hair growth	Belching or bloating
Chest pain/pressure	Kidney or bladder infection	NECK	Night sweats/ hot flash/flush	Change in bowel habits
Palpitations/fluttering		Thyroid disease	Pain with intercourse	Constipation
Swollen ankles		Lump	Vaginal dryness	Diarrhea
		Pain or stiffness	Decrease in sexual desire	

Do you consider your health to be: Excellent Good Fair Poor

Monthly breast exams Yes No

Regular exercise Yes No Type/frequency _____

Tobacco use Yes No If Yes or Quit, form/amount _____ For how long? _____

Caffeine-containing beverages (coffee, tea, cola) Yes No If Yes, how many cups per day? _____

Alcohol Yes No Type _____ How much? _____ How often? _____

Street drugs Yes No Type _____ How much? _____ How often? _____

History of mental health issues: Yes No If Yes, state type _____

History of sexually transmitted disease (STD) – enter "Y" or "N"

Chlamydia _____ HPV/Warts _____ Gonorrhea _____ Herpes _____ Other (type) _____

Do you plan pregnancy in the near future? Yes No

Are there any babies born with birth defects, hereditary, or genetic diseases in your family or your husband's Yes No

Type _____

Sexual orientation Heterosexual Homosexual Bisexual Number of sexual partners (lifetime) _____

Are you sexually active Yes No Age at first intercourse _____ Method of contraception _____

Have you lost or gained weight recently? Yes No Usual weight range _____

Have you ever been hit, slapped, kicked, or otherwise physically hurt by someone Yes No

Have you ever been forced to have sexual relations when you did not want to? Yes No Within the last 12 months? Yes No