**New Patient Health History Form**  
The purpose of this form is to gather your health history. Please be as thorough as possible.

|  |  |
| --- | --- |
| Patient Name: | Patient Date of Birth: |
| Employer/Position: | Primary Care Provider: |
| Preferred Pharmacy: | Partner’s Name: |

**Health Maintenance**  
Please note the year each test was most recently completed and whether the result was normal or abnormal.

|  |  |  |
| --- | --- | --- |
|  | Year | Result |
| Last Pap Smear |  |  |
| Last Mammogram |  |  |
| Last Bone Density |  |  |
| Last Colonoscopy |  |  |

**Past & Present Medical History**Please check any general medical problems of past or present significance.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Breast** | **Past** | **Present** | **Cardiovascular** | **Past** | **Present** | **Skin** | **Past** | **Present** |
| Abnormal Ultrasound |  |  | Cardiac Murmur |  |  | Acne |  |  |
| Cysts |  |  | Deep Vein Thrombosis |  |  | Cellulitis |  |  |
| Swelling |  |  | Fainting |  |  | Contact Dermatitis |  |  |
| Tenderness |  |  | Heart Attack |  |  | Eczema |  |  |
| Fibrocystic Breasts |  |  | High Blood Pressure |  |  | Herpes Zoster |  |  |
| Inverted Nipple(s) |  |  | High Cholesterol |  |  | Psoriasis |  |  |
| Nipple Discharge |  |  | Palpitations |  |  | Rash |  |  |
| **Endocrine/Metabolic** |  |  | **Hematologic** |  |  | **Urinary** |  |  |
| Abnormal Hair Growth |  |  | Anemia |  |  | Bladder Prolapse |  |  |
| Diabetes, Type I |  |  | Bleeding Tendency |  |  | Blood in Urine |  |  |
| Diabetes, Type II |  |  | Blood Transfusion |  |  | Chronic Renal Failure |  |  |
| Hyperthyroidism |  |  | Factor V Leiden |  |  | Kidney Disease |  |  |
| Hypothyroidism |  |  | MTHFR Deficiency |  |  | Kidney Stones |  |  |
| Vitamin Deficiency |  |  | Protein S Deficiency |  |  | Pain with Urination |  |  |
|  |  |  | Von Willebrand’s |  |  | Urinary Frequency |  |  |
|  |  |  |  |  |  | Recurrent UTI |  |  |
| **Digestive** |  |  | **Musculoskeletal** |  |  | **Respiratory** |  |  |
| Abdominal Pain |  |  | Fibromyalgia |  |  | Asthma |  |  |
| Heartburn |  |  | Osteopenia |  |  | Cystic Fibrosis |  |  |
| Hemorrhoids |  |  | Osteoporosis |  |  | Pulmonary Embolism |  |  |
| IBS |  |  |  |  |  | Sleep Apnea |  |  |
|  |  |  |  |  |  |  |  |  |
| **Psychiatric History** |  |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |
| Postpartum Depression |  |  |  |  |  |  |  |  |

Please note any serious illnesses or medical conditions you have or have had that were not included in the above list

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**Past Surgical History**Please list any operations you have had.

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| --- | --- | --- |
|  | Year | Additional Information |
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**GYN History**  
Please check any conditions you have or have had.

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| --- | --- | --- | --- |
| Abnormal Pap Smear | Genital Herpes | | Oral Herpes |
| Bartholin’s Gland Cyst | Gonorrhea | | Ovarian Cyst |
| Bleeding after intercourse | Hot Flashes | | Pain with Intercourse |
| Cervical Polyp | Infertility | | Pelvic Pain |
| Chlamydia | Irregular Periods | | Polycystic Ovarian Syndrome |
| Endometriosis | Lichen Sclerosis | | Postmenopausal Bleeding |
| Fibroids | No Periods | | Yeast Infections |
|  | |  | |
| Are you sexually active?  Yes  No | Is your partner:  Male  Female | | Which gender do you identify with:  Male  Female  Neither Male nor Female |

If applicable, what form of birth control do you use?

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| --- | --- | --- |
| Condoms | IUD | Nexplanon |
| Depo Provera | Partner Vasectomy | Withdrawal |
| Tubal Ligation/Essure | Oral Pill | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Obstetrical History**Please tell us more about your obstetrical history. If you have never been pregnant, please skip this section.

|  |  |
| --- | --- |
| Number of all Pregnancies: | Number of Full Term Deliveries: |
| Number of Premature Deliveries: | Number of Abortions: |
| Number of Miscarriages: | Number of Pregnancies with Twins/Triplets: |
| Number of Ectopic Pregnancies: | Number of Living Children: |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Delivery** | **Type of Delivery** | **Sex of Baby** | **Weight of Baby** |
|  |  |  |  |
|  |  |  |  |
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**Menstrual History**  
Please answer the following questions about your menstrual cycle.

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| --- | --- |
|  | Additional Information |
| Age at onset of menstruation |  |
| What was the first day of your last period |  |
| How many days do your periods last |  |
| Do you experience cramping or spotting during your cycle |  |
| Is your flow heavy, moderate or light |  |
| Do you experience spotting between cycles |  |
| Have you had any changes to your cycle in the past year |  |

**Medication List**Please list any medications, vitamins, or supplements you are currently taking as well as their dosage.

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| --- | --- |
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**Allergy List**Please list any allergies you currently have. This includes medications, food and environmental allergies.

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**Social History**Please tell us more about your social history.

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| **Substance Use** |  |
| Tobacco Use – How Many Packs Per Day \_\_\_\_\_\_\_\_\_\_ | Substance Abuse |
| Alcohol Use – How Many Drinks Per Week \_\_\_\_\_\_\_\_ |  |
| **Exercise** |  |
| Daily Exercise | What do you do for exercise? |
| Heavy Amount of Exercise (4 or more times a week) |  |
| Minimal Amount of Exercise (1-3 times a week) |  |
| No Regular Exercise |  |
| Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **Education** |  |
| College – 2 Years | Graduate Studies/Degree |
| College – 4 Years | PHD |
| GED | Student |
| **Personal History of** |  |
| Physical Abuse | Mental Abuse |
| Sexual Abuse | Other ­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Family History**Please tell us about your immediate family’s medical history.

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| --- | --- | --- | --- | --- |
| **Illness** |  | **Relative** | **Age of Onset** | **Living/Deceased** |
| Breast Cancer | YES  NO |  |  |  |
| Ovarian Cancer | YES  NO |  |  |  |
| Colon Cancer | YES  NO |  |  |  |
| Other Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ | YES  NO |  |  |  |
| Thyroid Disease | YES  NO |  |  |  |
| Diabetes | YES  NO |  |  |  |
| Cardiac Disease | YES  NO |  |  |  |
| Bleeding Disorder | YES  NO |  |  |  |
| Psychiatric Conditions | YES  NO |  |  |  |
| Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | YES  NO |  |  |  |