Comprehensive Health History Form

NAME:

LEGAL NAME:
(Name for billing)

BIRTH DATE:__________________ AGE: ______________

ALLERGIES (please list all your allergies to medications, foods, latex, etc.)

____

REASON FOR VISIT TODAY

____

____

**Please describe active concerns/symptoms.
**Multiple reasons may require separate appointments.

YOUR MEDICAL HISTORY

Current prescription medications: None ☐

____

____

Over the counter medications, herbs, supplements: None ☐

____

____

Yes	No	Do you now have, or have you had any of the following?
☐	☐	High blood pressure
☐	☐	Blood clots (arms/legs/chest)
☐	☐	Heart attack or stroke
☐	☐	High cholesterol/triglycerides
☐	☐	Migraines (with visual changes)
☐	☐	Lupus (SLE)
☐	☐	Cancer: What type?__________________When? _________
☐	☐	Blood problems (ie sickle cell anemia, hemophilia, low iron)
☐	☐	Gall bladder disease
☐	☐	Surgeries - List type and date: ______________________
☐	☐	Thyroid problems
☐	☐	Breast disease
☐	☐	Colon or colorectal problems
☐	☐	Colonoscopy - date: ________________________________
☐	☐	Kidney or bladder problems (i.e., infections, UTI)
☐	☐	Liver disease (i.e., hepatitis, mono, jaundice, cirrhosis)
☐	☐	Diabetes
☐	☐	Epilepsy or convulsions
☐	☐	Osteoporosis
☐	☐	Depression or other mental health issues
☐	☐	Addiction
☐	☐	Asthma
☐	☐	Any other medical conditions ________________________

FAMILY MEDICAL HISTORY

☐ I'm adopted

Yes	No	Have your parents, siblings, grandparents, or aunts/uncles had any of the following?
☐	☐	Blood clots in arms/legs/chest
☐	☐	Bleeding problems
☐	☐	High blood pressure
☐	☐	High cholesterol/triglycerides
☐	☐	Breast/ovarian/uterine/colon cancer other cancer (please circle)_________________________
☐	☐	Heart attack
☐	☐	Stroke
☐	☐	Diabetes
☐	☐	Birth defects
☐	☐	Alcohol/drug abuse
☐	☐	Osteoporosis

Note: If you are under 18, we are required by law to report any case of sexual assault or abuse that has not already been reported.

YOUR PERSONAL HISTORY

Yes	No	
☐	☐	Do you smoke/vape or use tobacco currently? What type? __________________________ How much per day? _____________________
☐	☐	Have you used tobacco in the past? When did you quit? _________________
☐	☐	Do you drink alcohol? How many drinks a day? ________ Per week?__________
☐	☐	Do you use marijuana? How often? ______________
☐	☐	In the past year, have you used an illegal drug ora prescription drug for non-medical reasons?
☐	☐	Have you ever been hit, slapped, kicked, shaken,or hurt by anyone?
☐	☐	Have you ever been forced to engage in sexual activities?

NUTRITION

Yes	No	
☐	☐	Are you happy with your weight and diet?If no, describe: ______________________
☐	☐	Do you exercise regularly? Describe: ____

IMMUNIZATIONS

Yes	No	Don't Know	
☐	☐	☐	Are you up to date on vaccines?
☐	☐	☐	HPV (human papilloma virus) vaccine? Date______________
☐	☐	☐	Flu vaccine? Date______________

YOUR REPRODUCTIVE HEALTH

FEMALE/ASSIGNED FEMALE AT BIRTH ☐ I've had SRS

YOUR MENSTRUAL HISTORY

Age of first period ___________

First day of your last period:____________________, or:

☐ I don't get a period due to hormones, an IUD, or an implant

☐ I'm post-menopausal, and it was: ☐ Natural ☐ Surgical

Year of menopause _______________

Yes	No	
☐	☐	Do you get a period every month? Is the flow: ☐ light ☐ medium ☐ heavy
☐	☐	Do you have cramps with your periods?

YOUR PREGNANCY HISTORY

How many times have you been pregnant?__________, or: ☐ Never

Your age at first birth?_

How many living children do you have? __________

Dates of any vaginal births: ______________________________

Dates of any C-sections: ______________________________

Dates of any miscarriages: ______________________________

Dates of any abortions: ______________________________

Dates of any tubal pregnancies: ______________________________

Are you breast-feeding now? Yes ☐ No ☐

YOUR GYNECOLOGICAL HISTORY

When was your last Pap test?__________________________ ☐ Never

When was your last mammogram?______________________ ☐ Never

Yes	No	Have you had any of the following?
☐	☐	Abnormal Pap test? When? ____________________
☐	☐	Abnormal mammogram? When? ________________
☐	☐	Biopsy or treatment of your cervix: When? ___________________________
☐	☐	Ovary problems
☐	☐	Uterus problems or uterine fibroids
☐	☐	Pelvic Inflammatory Disease (PID)
☐	☐	Vaginal infections (yeast or bacterial vaginosis)

YOUR BIRTH CONTROL HISTORY

How do you prevent pregnancy? ________________________________

Yes	No	
☐	☐	Have you used any birth control methods that you have? had a problem with? What method(s)? ______________________________
☐	☐	In the last 5 days or since your last period, have you had sex without birth control (includes condoms)? When? ________________________________

ALL PATIENTS

Have YOU or YOUR PARTNER ever had the following:

Yes	No	
☐	☐	Chlamydia
☐	☐	Gonorrhea
☐	☐	Genital warts/Human Papilloma Virus/HPV
☐	☐	Syphilis
☐	☐	Genital Herpes
☐	☐	Trich
☐	☐	Non-gonococcal urethritis (NGU)
☐	☐	Have you received a tattoo in an unsterile environment
☐	☐	Have you or your sexual partner(s) ever used needles to shoot drugs?
☐	☐	Have you or your sexual partner(s) ever exchangedsex for drugs or money?
☐	☐	STI testing? When? ______________
☐	☐	HIV? Positive test? When? ______________
☐	☐	Have you had a new partner in the past 2 months?
☐	☐	Does your sex partner have other partners?

How do you protect yourself from STIs? (Condom use: always/sometimes/never) _________________________

1. How many sexual partners have you had:
   in the past 2 months? __________
   in the past year? __________
2. My sex partner(s) have a: ☐ Penis ☐ Vagina ☐ __________
3. What kind of sex do you have:
   ☐ Vaginal ☐ Oral ☐ Anal: give ☐ receive ☐ both ☐
   ☐ ____________ ☐ None
4. When was the last time you had sex? ___________________________
5. Have any of your male partners had sex with other males? Yes ☐ ☐ No ☐ Don't know ☐ N/A

MALE/ASSIGNED MALE AT BIRTH ☐ I've had SRS

Yes	No	
☐	☐	Do you have abnormal discharge from the penis now? Describe: ________________________________
☐	☐	Do you have now or in the past a sore or lump on your penis, scrotum or testicles? Describe: ___________________________When? ________

YOUR REPRODUCTIVE HISTORY

Yes	No	
☐	☐	Do you want children in the future?
☐	☐	Do you want to become pregnant in the next year?

PATIENT SIGNATURE: ______________________________

TODAY'S DATE: _______________

PROVIDER SIGNATURE:____________________DATE: __________