Patient Health History

Patient Name: _____ Age: _____ DOB: _____

Emergency Contact: _____ Phone: _____

Family Doctor: _____ Referred By: _____

Preferred Pharmacy: _____ Address or Phone: _____

Which method do you use to chart your cycles? (Creighton, Billings, FEMM) _____

PAST MEDICAL HISTORY

Condition	Current	History	No	Condition	Current	History	No
Abnormal Pap Smear				Hypertension			
Anemia				Infertility			
Anesthesia Complication				Kidney Stone			
Anxiety				Liver Disease			
Asthma				Lupus			
Blood Clots in Legs or Lungs				Migraine			
Blood Transfusion				Miscarriage			
Breast Disorder				M THFR			
Cancer of the Breast				Mitral Valve Prolapse			
Cancer, other				PAI-1			
Cardiovascular Disease				Pelvic Inflammatory Disease			
Depression				PCOS			
Diabetes				Seizures/Convulsions			
Endometriosis				Sexually Transmitted Disease			
Epilepsy				Stroke			
Factor 5				Thyroid Disorder			
Fibromyalgia				Tuberculosis			
Heart Murmur				Ulcer			
Herpes				Von Willebrand's Disease			
Date of Last Pap Smear: / / Normal Abnormal				Date of Last Mammogram: / / Normal Abnormal			
Date of Last Dexa Scan: / / Normal Abnormal				Date of Last Colonoscopy: / / Normal Abnormal			
Other:							
Willing to receive blood products, if necessary? Yes No							

OPERATIONS / SURGERIES

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
1)		4)	
2)		5)	
3)		6)	

MEDICATIONS

(include prescriptions, over the counter, herbal, and vitamins)

MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN
1)		
2)		
3)		
4)		
5)		

MEDICATION ALLERGIES

Do you have any drug allergies? No Yes (If yes, please list below)

MEDICATION	REACTION
1)	
2)	
3)	

FAMILY MEDICAL HISTORY

(Do any of your children, siblings, or parents have the following?)

ILLNESS	YES	RELATIONSHIP	ILLNESS	YES	RELATIONSHIP
None			Cardiovascular Disease		
Adopted			Depression		
Blood Clot in Legs or Lungs			Diabetes		
Cancer, Breast			Hypertension		
Cancer, Colon			Osteoporosis		
Cancer, Ovarian			Polyp – anal/rectal/colon		
Cancer, Uterine			Stroke		
Cancer. Other			Thyroid Disorder		

pearl HEALTH

GENETIC HISTORY / SCREENING

(Self, partner, or other family member)

CONDITION	YES	RELATIONSHIP	CONDITION	YES	RELATIONSHIP
Cats – do you have exposure?			Diabetes – self only		
Chickenpox			Down Syndrome		
Congenital Heart Defect			Infertility		
Cystic Fibrosis			Rh Sensitized		
DES Exposure			Sickle Cell Anemia		

REPRODUCTIVE HISTORY

Age of First Menses:	Cycle Interval (number of days from start to start):
Menses Duration (Number of days of bleeding):	Flow (circle): Light Medium Heavy
Number of Tampons per day:	Number of Pads per day:
Last Menstrual Period: / /	Certain of LMP date? (circle) YES NO
Menopause Status: (circle) Pre Peri Post	Age at Menopause:
Method of Family Planning:	Sexually Active? (circle) YES NO
Bleeding between Periods: (circle) YES NO	Pain with Menses? (circle) YES NO

PREGNANCY HISTORY

Total Pregnancies: ____/Full Term___/Preterm:___/Miscarriage:____Abortion:____/Ectopic:____/Multiple:____/Living:___

Date	Gest. Age	Hours in Labor	Birth Weight	Sex	Type of Delivery	Anesthesia	Comments	Facility/Provider

EXERCISE, SLEEP, AND NUTRITION

Amount of Exercise? Active Heavy Medium Minimal None (Sedentary)	
How many hours of sleep do you get each night on average?	
Describe sleeping difficulties, if any:	
Do you have sensitivities to certain foods? If yes, please explain:	
Please record what you eat in a typical day:	
Breakfast:	Snacks:
Lunch	Fluids
Dinner:	

SOCIAL HISTORY

Marital Status: (circle)	Single	Married	Widowed	Divorced	Spouse/Partner Name:
Occupation:				Religion:	
Alcohol:	Never	Current	Former	Amount per Week	
Drugs:	Never	Current	Former	Amount per Week	
Smoking:	Never	Current	Former	Amount per Week	