HEALTH HISTORY FORM

PATIENT'S NAME: _____ **TODAY'S DATE:** ____/____/____

Date of Birth: ____/____/____ Age: _____ Primary Care Provider: _____

Height: _____

Your Occupation: _____ Who referred you here? _____

Marital Status: _____ Husband's/Partner's first name: _____

FIRST DAY of LAST MENSTRUAL PERIOD: ____/____/____

REASON FOR VISIT TODAY: _____

ALLERGIES *Please list all allergies: medications, latex, severe food or environmental* **None** □ **See attached List:** □

_____

_____

_____

MEDICATIONS: **None** □ **See attached List** □

Please list all prescribed medications, over the counter medications, and supplements you are currently taking

_____

_____

_____

_____

MEDICAL HISTORY:

Have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Abnormal pap			Kidney disease			Cancer (Leukemia, other)		
Low platelet count			Liver disease			Stroke		
Anesthesia complications			Lupus			Migraine headaches		
Asthma			Mental Illness			Frequent bladder infections		
Anemia (low iron, Sickle Cell, Thalassemia)			Post Partum Depression			STI: Herpes, Gonorrhea, Chlamydia, Syphilis, HPV		
Diabetes mellitus			Rh incompatibility			Eating disorder		
Heart problems			Seizures			Blood transfusion(s), year?		
HIV/AIDS			Chicken Pox			Severe anxiety		
High Blood Pressure			Thyroid problems			Severe depression		
Infertility			Trauma/Violence			Other: (please specify)		

SURGICAL HISTORY:

Please list all past operations you have had:

Year	Surgery Type	Reason	Any Complications?

OBSTETRIC HISTORY:

Please list ALL the pregnancies you have had, in chronological order, including miscarriages, abortions, ectopic and other abnormal pregnancies:

Month/Day/Year	Sex of child	Weeks early or late	Length of labor	Birth weight	Type of delivery	Anesthesia	Any problems during the pregnancy/delivery or after the delivery

**** Please complete the other side ****

GYNECOLOGIC HISTORY:

Age at FIRST menstrual period: _____
Age at LAST period, if menopausal: _____

How many days do your periods last? _____
How many days between the start of one period and the start of the next period? _____

Flow: Heavy ☐ Moderate ☐ Scant ☐

Clots: Yes ☐ No ☐
Cramps: Severe ☐ Moderate ☐ Infrequent ☐

Are you currently sexually active? Yes ☐ No ☐
Have you ever had sex? Yes ☐ No ☐
Sexual partners are: Men ☐ Women ☐ Both ☐
What do you currently do to prevent pregnancy?
_____
What have you done in the past to prevent pregnancy?
_____

Date of last Pap smear: _____
Date of last Mammogram: _____
Date of last Bone Density Test: _____

Date of last Colonoscopy: _____
Have you had the HPV Vaccine? Yes ☐ No ☐

Do you have any of the following?

Bleeding between periods: Yes ☐ No ☐
Bleeding after intercourse: Yes ☐ No ☐
Pain with intercourse: Yes ☐ No ☐

Problems with sexual response: Yes ☐ No ☐
History of sexual trauma/assault: Yes ☐ No ☐

Urine leakage: Yes ☐ No ☐

HABITS/SOCIAL INFORMATION:

	Yes	No		
Do you use any tobacco products? If former smoker, quit date:			If yes, how many times a day/week?	
Do you use any cannabis products?			If yes, how many times a day/week?	
Do you drink alcohol?			How many drinks/week?	
Do you use recreational drugs?			Specify which drugs, how often used:	

Place of Birth: _____ Who do you live with? _____

EXERCISE: On average, how many days per week do you do moderate to strenuous exercise (that causes a moderate to heavy sweat)? _____ None: ☐
For how many minutes/hours do you do such exercise? _____
What exercises/physical activities do you do?
_____

SOCIAL STRESSORS:

Have you recently experienced any major life changes or events? i.e *marital status change, job change, new living arrangements, births, deaths in the family, physical or emotional traumatic events:*
None: ☐

_____
_____
_____

FAMILY HEALTH INFORMATION:

Please indicate the status of your family members:

	Alive		If deceased		If alive
	Yes	No	Age at death	Cause of death	Health conditions, illnesses:
Father					
Mother					
Maternal grandmother					
Maternal grandfather					
Paternal grandmother					
Paternal grandfather					
Brothers (please list each separately)					
Sisters (please list each separately)					

PATIENT HEALTH QUESTIONNAIRE (PHQ-2)

NAME: _____

DATE: _____

This is a quick tool to identify depression. Depression can seriously affect your health. Please answer the following questions:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, or hopeless?	0	1	2	3

0 _____ + _____ + _____

Total Score: _____

My Total Score: 0 - 2 --> 

My Total Score: 3 - 6 --> 

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____