



PATIENT HISTORY FORM

TODAY'S DATE _____ Your age _____ DATE OF BIRTH _____

YOUR NAME (Last) _____ (First) _____ (M.I.) _____

REFERRED HERE BY _____

PAST MEDICAL HISTORY

*(If YOU have EVER had any of these conditions, please indicate with an X or a √)
Thank you for answering all of the following questions. Your health is important to us.*

Breast Conditions

- _____ Abnormal Mammogram
- _____ Breast Cancer
- _____ Breast Implants
- _____ Fibrocystic Breast
- _____ Other _____

Gyn Conditions

- _____ Abnormal Pap Smear
- _____ Endometriosis
- _____ Fibroids
- _____ Herpes (circle which type- oral and/or genital)
- _____ HPV (Human Papilloma Virus)
- _____ Menopause
- _____ Ovarian Cysts or PCO (polycystic ovary)
- _____ Pelvic Organ Prolapse
- _____ Severe PMS
- _____ Other _____

Heart or Circulation Conditions (Cardiovascular)

- _____ Blood Clot (DVT or Pulmonary Embolism)
- _____ Congenital Heart Disease
- _____ Fainting (Syncope)
- _____ High Blood Pressure
- _____ Varicose Veins
- _____ Other _____

Endocrine (Glandular) Disorders

- _____ Diabetes (circle which type- I or II)
- _____ Pituitary Gland Disease
- _____ Thyroid Disease
- _____ Other _____

Immune System Diseases

- _____ Chronic Fatigue Syndrome or EBV
- _____ Fibromyalgia
- _____ Lupus or Rheumatoid Arthritis
- _____ Other _____

Gastrointestinal (GI) Problems

- _____ Blood in Stool
- _____ Crohn's Disease or Ulcerative Colitis
- _____ Hepatitis
- _____ Irritable Bowel Syndrome
- _____ Stomach Ulcer
- _____ Other _____

Blood (Hematologic) Disorders

- _____ Anemia
- _____ Abnormal Hemoglobin
- _____ Clotting Disorder
- _____ Sickle Cell Trait or Disease
- _____ Thalassemia
- _____ Vitamin Deficiency
- _____ Other _____

Musculoskeletal Disorders

- _____ Fractures or Broken Bones
- _____ Arthritis or Joint Pain
- _____ Scoliosis
- _____ Severe Back Pain or Back Disease
- _____ Other _____

Neurologic Disorders

- _____ Migraines or Severe Headaches
- _____ Seizure Disorder (Epilepsy)
- _____ TIA or Stroke
- _____ Other _____

Psychiatric or Emotional Conditions

- _____ Bipolar (Manic-Depressive)
- _____ Nervous Breakdown
- _____ OCD (Obsessive-Compulsive)
- _____ Severe Anxiety or Panic Attacks
- _____ Severe Depression or Postpartum Depression
- _____ Other _____

Respiratory (Lung) or ENT Disorders

- Allergies, Hay Fever
- Asthma or Bronchitis/Pneumonia
- Lung Cancer
- Sinusitis or Sinus Problems
- Sleep Apnea
- Other _____

Urinary (Urological) Disorders

- Frequent Bladder Infections
- Kidney Stones or Other Problems
- Other _____

Skin Conditions

- Acne (severe)
- Eczema
- Excess Hair Growth
- Hives
- Psoriasis
- Other _____

What is your Height? _____

What is your recent weight? _____

REVIEW OF SYSTEMS

(Are you currently experiencing any of the following symptoms to a significant degree?)

(If so, please indicate with an X or a √)

General

- Fatigue or Weakness
- Fever, Chills or Sweats
- Loss of Appetite
- Unexplained gain or loss of weight

Eyes, Ears, Nose and Throat

- Dizziness
- Nose Bleeds
- Sore Throat
- Vision or Hearing Changes

Breasts

- Breast Lump
- Breast Pain or Tenderness
- Nipple Discharge (other than white)

Cardiovascular

- Chest Pain
- Irregular Heartbeat
- Palpitations

Respiratory

- Chronic Cough
- Shortness of Breath
- Wheezing

Gastrointestinal

- Diarrhea (watery stool)
- Heartburn
- Nausea or Vomiting
- Severe Constipation

Urinary

- Burning with Urination
- Frequent Urination
- Leakage of Urine
- Waking at night 2 or more times

Gynecologic

- Bleeding After Intercourse
- Bleeding Between Periods
- Bumps or Sores in Genital Area
- Cycles Longer than 35 days?
- Heavy Flow more than 3 days?
- Pain Before or During Periods
- Pain with Ovulation
- Periods last 8 or more days
- Severe Cramps with Periods
- Vaginal Discharge

Skin

- Itching
- Moles or Sores
- Rash

Neurologic

- Dizziness
- Headaches
- Memory Problems

Musculoskeletal

- Joint Pain (Back, Knee, Wrist, Hip)
- Joint Swelling
- Muscle Cramping or Pain

Endocrine (Glandular)

- Excessive Hair
- Excessive Sex Drive
- Hair Falling Out
- Intolerance to Heat or Cold
- Low Sex Drive

Psychiatric

- Anxiety, Worries, Stress (Excessive)
- Depressed
- Feeling Out of Control

PAST SURGICAL HISTORY

Surgery/Reason	Reason	When

PRESCRIPTION MEDICATIONS YOU ARE TAKING

Drug name	Dose	How Often	Start Date	Prescribed by

DRUG STORE MEDICATION, VITAMINS AND SUPPLEMENTS YOU ARE TAKING

Product name	Dose (if known)	How Often	Start Date	Reason

Pharmacy Name: _____ Phone # _____

Pharmacy Address: _____ Fax # _____

ALLERGIES (circle choices)

Do you have any known allergies? NO ALLERGIES Allergic to Latex? YES NO

If yes, please list all allergies and your allergic reaction

Allergic to	Reaction

FAMILY MEDICAL HISTORY

*(If **ANY** close relative of yours - such as grandparents, parents, brothers, and sisters – has **EVER HAD** or **CURRENTLY HAS** any of the problems listed below.*

CONDITION	In the open space below, please indicate which specific condition Place an X for either M (<u>mother's side</u>) or F (<u>Father's side</u>)	M	F
1. DIABETES, HIGH CHOLESTEROL, THYROID DISEASE			
2. HIGH BLOOD PRESSURE, HEART ATTACK, BLOOD CLOTS, STROKE			
3. TUBERCULOSIS, ASTHMA, OTHER LUNG DISEASE			
4. BREAST DISEASE, BREAST CANCER			
5. STOMACH, GI or COLON DISEASE or CANCER			
6. KIDNEY DISEASE, KIDNEY STONES			
7. GYN DISEASES, OVARIAN CANCER, UTERINE FIBROIDS			
8. MUSCULOSKELETAL DISEASES, OSTEOPOROSIS			
9. NEUROLOGIC or NERVOUS SYSTEM DISEASE, MIGRAINES			
10. SEVERE DEPRESSION or OTHER PSYCHIATRIC CONDITION			
11. GENETIC DISEASE or BIRTH DEFECTS of ANY KIND			
12. LEUKEMIA, LYMPHOMA or ANY BLOOD or BONE MARROW DISEASE			
13. ANY RELATIVE EVER HAD A BONE MARROW TRANSPLANT			
14. ANY TYPE of CANCER or MALIGNANT TUMORS			

SOCIAL HISTORY

ALCOHOL USE: NONE or _____

DRUG USE: NONE or _____

EXERCISE: _____

HAZARDOUS EXPOSURES: NONE or _____

OCCUPATION: _____

HOBBIES: _____

MISC: _____

MENSTRUAL HISTORY

AGE of FIRST MENSTRUAL PERIOD _____ CYCLE LENGTH (28 days or ?) _____

of DAYS of BLEEDING with a PERIOD _____ # days heavy _____ # days light/spotting _____

DATE of LAST NORMAL MENSTRUAL PERIOD (if abnormal, describe) _____

BIRTH CONTROL METHOD _____ LAST Pap Smear (MM/YY) _____

(*period means # days of bleeding; cycle length means total # of bleeding and non-bleeding days until the next period begins)

PREGNANCY SUMMARY (how many...?)

Total Number of Pregnancies	Full Term Births (> 37 wks)	Premature Births (< 37 wks)	Terminations	Miscarriages	Ectopic pregnancies	Number of Living Children

Comments: _____

PREGNANCY DETAILS

Child's Birthdate	# weeks at Delivery	Length of Labor	Birth Wt.	M or F	Type of Delivery (Vaginal or C/S)	Anesthesia	Complications/ Problems	Location

OBSTETRICAL HISTORY (Supplement)

TODAY'S DATE _____ Your age _____ DATE OF BIRTH _____

YOUR NAME (Last) _____ (First) _____ (M.I.) _____

Your spouse/partner's full name _____

ADDITIONAL PREGNANCY HISTORY

What was the FIRST day of the last menstrual period? _____ Is this date definite? (Y/N) _____

Cycles regular? (Y/N) _____ Cycle length (avg=28 days) _____ Date of first pos. preg. Test _____

Conception (check one): normal Date of conception _____ IUI (date _____)

IVF fresh cycle (date of egg retrieval _____) IVF frozen embryo (Date of embryo transfer _____)

What was your weight just before becoming pregnant? _____ What is your height? _____

When was your last pap smear? _____ By whom? _____ Was it normal? YES NO

INFECTION SCREENING

1. DO YOU LIVE WITH SOMEONE WHO MIGHT HAVE TUBERCULOSIS?	YES	NO
2. DO YOU or YOUR PARTNER HAVE A HISTORY OF GENITAL HERPES?	YES	NO
3. HAVE YOU HAD A SKIN RASH or VIRAL ILLNESS SINCE YOUR LAST PERIOD?	YES	NO
4. HAVE YOU EVER TESTED POSITIVE FOR HEPATITIS B OR C	YES	NO
5. HAVE YOU EVER HAD GONORRHEA, SYPHYLLIS, CHLAMYDIA or VENEREAL WARTS? (circle any that apply)	YES	NO
6. DO YOU OR YOUR PARTNER HAVE A HISTORY OF A BLOOD TRANSFUSION?	YES	NO
7. DO YOU OR YOUR PARTNER HAVE A HISTORY OF IV DRUG USE?	YES	NO

Details for any YES answers: _____

FAMILY GENETIC SCREENING

(If **ANY** close relative of yours - such as brothers, sisters, parents, other children - has EVER HAD or CURRENTLY HAS any of the problems listed below, please CIRCLE YES)

1. HISTORY of THALASSEMIA or HEMOGLOBIN DISORDER	YES	NO
2. HISTORY of NEURAL TUBE DEFECT (spina bifida)	YES	NO
3. HISTORY of CONGENITAL HEART DEFECT	YES	NO
4. HISTORY of DOWN SYNDROME	YES	NO
5. IS EITHER PARENT ADOPTED?	YES	NO
6. IS THE MOTHER or THE FATHER of THE BABY ASHKENAZI JEWISH or CAJUN? If yes, has any genetic testing been done?	YES Yes	NO No
7. A. HISTORY of SICKLE-CELL ANEMIA B. IS THE MOTHER or THE FATHER of THE BABY AFRICAN-AMERICAN? If yes, has any Sickle-cell Anemia carrier testing been done?	YES YES Yes	NO NO No
8. HISTORY of HEMOPHILIA or MUSCULAR DYSTROPHY	YES	NO
9. A. HISTORY of CYSTIC FIBROSIS B. IS THE MOTHER or THE FATHER OF THE BABY CAUCASIAN/EUROPEAN? If yes, has any Cystic Fibrosis carrier testing been done?	YES YES Yes	NO NO No
10. HISTORY of HUNTINGTON'S DISEASE (HUNTINGTON'S CHOREA)	YES	NO
11. HISTORY of MENTAL RETARDATION If yes, was testing for Fragile X chromosome done?	YES Yes	NO No
12. HISTORY of ANY INHERITABLE GENETIC SYNDROME or ANY BIRTH DEFECTS	YES	NO
13. HISTORY of MATERNAL PKU OR OTHER METABOLIC SYNDROME	YES	NO
14. HISTORY OF STILLBIRTH OR 2 OR MORE MISCARRIAGES	YES	NO

Details for any YES answers: _____

