Confidential Health History Form

VALLEY WOMENS HEALTHCARE MEDICAL GROUP

Wade Dickinson, M.D.

Name: _____ **DOB:** _____ **Date:** _____

Yes	No		
		Do you take prescribed medications?	**List:** _____
		Are you allergic to any medications?	**List:** _____
		Are you adopted?	

FAMILY HISTORY: Do your Parents, brothers, sisters, or children have any of the following? If yes, who?

Yes	No	Condition	Who?	Yes	No	Condition	Who?
		Alcohol/Drug Abuse				Mental Illness	
		Arthritis				Heart Attack	
		Severe Anemia				High Cholesterol	
		Bleeding Problems				Stroke	
		Diabetes				Birth Defect/Genetic Problems (Such as: sickle cell anemia, PKU, Tay Sachs)	
		Cancer: What Kind?					
		High Blood Pressure					

MEDICAL HISTORY: Have you had problems with:

Yes	No	Symptom	Comments	Yes	No	Symptom	Comments
		Allergies: To What?				Black or bloody stools	
		Skin				Kidney	
		Eyes/Vision (except glasses)				Holding urine / dribbling	
						Bladder infection	
		Ears/hearing				Gonorrhea, syphilis, herpes,warts	
		Mouth/teeth					
		Bleeding or clotting (not with your period)				HIV	
						Bone injuries: broken bones	
		Anemia				Back pain	
		Cancer: what kind?				Joint problems: arthritis	
		Diabetes					
		Thyroid disease		**Have you had any of the following shots:**			
		Headaches		**Yes**	**No**	**Vaccine**	
		Seizures/epilepsy				TDaP	
		Psychiatric problems				Rubella (German Measles)	
		Suicidal depression				Polio	
		High cholesterol				Hepatitis A	
		Heart disease / problem				Hepatitis B	
		High blood pressure				Gardasil	
		Asthma					
		Tuberculosis		**Yes**	**No**	**Symptom**	
		Other lung disease				Vaginal infection	
		Positive PPD (skin test for TB)				Pelvic infection (PID)	
		Breast: lump/tumor/ discharge/surgery				Pelvic tumor/fibroid	
						Abnormal pap?	Date: _____
		Gall bladder or stones				Mammogram ?	Date: _____
		Liver disease/hepatitis/ jaundice/mono		**HOSPITALIZATIONS/SURGERIES: (List all except pregnancy)**			
		Stomach		Year ____ Reason: _____			
		Chicken Pox		Year ____ Reason: _____			
		Parasites		Year ____ Reason: _____			
		Ulcer		Year ____ Reason: _____			

Staff Use Only
Comments/ Updates

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Name: _____ **DOB:** _____ **Date:** _____

MEDICAL HISTORY (Cont.)

Yes	No	Question		Explain/Details
		Do you take street drugs?	If so, List them	
		Do you smoke cigarettes?	If so, # cigarettes/Day and How Long?	
		Do you drink alcohol?	If so, # drinks/day and Per/Week	
		Do you consider yourself to have (had) a problem with drugs or alcohol?		Explain:

Yes	No	Question	Explain/Details
		Are you working?	
		Are you exposed to dangerous chemicals in your work? If Yes, Explain	
		Do you consider your diet healthy?	
		Do you ever make yourself vomit after eating or do you take laxatives to lose weight?	
		Do you exercise? What type? How many times a week?	
		Do you have intercourse? If yes, what age did you begin?	
		Have you had sex with another person in recent months?	
		Number of sex partners in the last 6 months? Male, Female, or Both?	
		Do you use condoms? How often? (Always, Sometimes, Never)	
		Does your partner have other sexual partner(s)?	
		Are you currently, or have you ever been, in a relationship where you were threatened or made to feel afraid?	
		Have you ever been hit, kicked, slapped, pushed or shoved by your partner?	
		Have you ever been forced or pressured to engage in sexual activity when you did not want to?	
		Have you ever been raped?	
		What questions do you have about sex?	

Menstrual History

Yes	No		
		Is this your first pelvic exam?	
		Age period started:	

Periods are (circle all that apply): Regular, Irregular, Painful, Light, Moderate, Heavy

Periods come every _____ Days, and last _____ Days.

Do you have bleeding between periods? (circle one) Yes / No / Sometimes

First Day of Last Menstrual Period: _____

Date of Last pregnancy or birth: _____

Yes	No	
		Are you breast feeding?

Pregancy History

Number of:	
_____	Abortions
_____	Miscarriages
_____	Still Births
_____	Cesareans
_____	Ectopic Pregancies (tubal)
_____	Premature Births
_____	Normal Vaginal Pregnancies
_____	**Total # of Pregnancies**
_____	Age at first pregnancy

Complications and/or comments on these pregnancies:

Birth Control History

If you use birth control, what methods have you used?

	Pills If pills, what kind have you used? _____
	Depo Injection
	Diaphragm/Cervical Cap
	Foam, Suppositories, Cream, Jellies
	Condoms, Rubbers
	Withdrawl or pulling out
	Rhythm, Calendar, or Natural Family Planning
	Norplant/Nexplanon
	IUD
	Tubal Ligation (sterilization)
	None

Current Birth Control Method: _____

I want to change my method to: _____

List any problems with these methods: _____

Patient/Responsible Party Signature **Date**

Clinician/Physician Signature **Date**