Confidential Health History Form

Camilla Marquez, 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
		Allergies: To What?	
		Skin	
		Eyes/Vision (except glasses)	
		Ears/hearing	
		Mouth/teeth	
		Bleeding or clotting (not with your period)	
		Anemia	
		Cancer: what kind?	
		Diabetes	
		Thyroid disease	
		Headaches	
		Seizures/epilepsy	
		Psychiatric problems	
		Suicidal depression	
		High cholesterol	
		Heart disease / problem	
		High blood pressure	
		Asthma	
		Tuberculosis	
		Other lung disease	
		Positive PPD (skin test for TB)	
		Breast: lump/tumor/ discharge/surgery	
		Gall bladder or stones	
		Liver disease/hepatitis/ jaundice/mono	
		Stomach	
		Chicken Pox	
		Parasites	
		Ulcer	

Yes	No	Symptom	Comments
		Black or bloody stools	
		Kidney	
		Holding urine / dribbling	
		Bladder infection	
		Gonorrhea, syphilis, herpes,warts	
		HIV	
		Bone injuries: broken bones	
		Back pain	
		Joint problems: arthritis	

Have you had any of the following shots:

Yes	No	Vaccine	
		TDaP	
		Rubella (German Measles)	
		Polio	
		Hepatitis A	
		Hepatitis B	
		Gardasil	

Yes	No	Symptom	
		Vaginal infection	
		Pelvic infection (PID)	
		Pelvic tumor/fibroid	
		Abnormal pap?	Date: ______________
		Mammogram ?	Date: ______________

HOSPITALIZATIONS/SURGERIES: (List all except pregnancy)

Year ____ Reason: ______________________________

Year ____ Reason: ______________________________

Year ____ Reason: ______________________________

Year ____ Reason: ______________________________

Staff Use Only
Comments/ Updates

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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

First Day of Last Menstrual Period: ______________________

Date of Last pregnancy or birth: ______________________

Yes	No	
		Are you breast feeding?

Periods come every __________ Days, and last __________ Days.

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

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**