Confidential Health History Form

VALLEY WOMENS HEALTHCARE MEDICAL GROUP

Richard Shebelut, 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

Confidential Health History Form

Richard Shebelut, M.D.

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

First Day of Last Menstrual Period: ______________________

Date of Last pregnancy or birth: ____________

Periods come every __________ Days, and last __________ Days.

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

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**