Women's Wellness and Maternity Center

Extensive Health History Form

Extensive Health History								Health Provider Notes
								Please Do Not Write In This Area
Last Name: First: Age: Sex:								
Current Problem:								
Have you or any blood relative had:								
			Yes	No	Who		Year	
Allergies, asthma, hay fever								
Anemia								
Alcoholism								
Arthritis								
Bleeding problems								
Birth defects								
Cancer								
Diabetes								
Emphysema								
Epilesy or seizures								
Heart trouble								
Mental illness (depression,								
anxiety, panic attacks)								
Migraine headaches								
Rheumatic fever								
Stroke								
Suicide								
Thyroid disease/goiter								
Tuberculosis								
Ulcers								
Sexually transmitted infection								
Chlamydia								
Gonorrhea								
Herpes								
HPV/warts								
Syphilis								
Osteoporosis								
Glaucoma								
Gallstones								
Rubella / Berman Measles								
Toxoplasmosis								
Cytomeglovirus								
Hepatitis A								
Hepatitis B								
Hepatitis C								
Names of other Present MDs					**Childhood**			

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What did you see them for:				Year	**Immunizations**		Year	
					Tetanus			
					Diphtheria			
					Polio			
					Pneumovax			
					Flu shot			
					Last TB Test			
					Positive Negative			
Allergies: Please list type and reaction None								
Name of Drug/Item			Reaction					

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Patient Name:							
Medications							Health Provider Notes
Have you EVER		Yes	No	How long(years)		Brand/Descr/Dose	Please Don't
TAKEN:							Write In This
Blood pressure pills							Area
Cortisone/steroid							
Diet pills							
Diabetes pills							
Thyroid pills							
Tranquilizers							
Water pills							
Are you NOW taking:							
Antacids							
Asprin or Antibiotics							
Blood thinner pills							
Laxatives							
Pain pills							
Sleeping pills							
Vitamins							
Herbal Supplement							
OTHER *Please list*							
OB/GYN HISTORY							
		Yes	No	Answer			
Date of last menstrual period							
Are your periods regular?							
No. of days between periods							
No. of days periods last							
Spotting betweeen periods							
Do you do self breast exams monthly?							
Are you pregnant?							
No. of pregnacies							
Date of last pregnancy							
No. of live births							
Complication with pregnancy?							
Complication with delivery?							
Hours in labor							
Pain Medication							
On due date were you early or late?							
No. of abortions or miscarrages							
Date of last pap smear							
Was It normal?							
Any other abnormal Pap?							
Treatment for abnormal Pap							
Are you using anything to avoid pregnancy?							
Type of contraception							
Type of contraceptives used in past							
Did your mother take DES during her pregnancy?							

Last mammogram							
Surgical History: Name of Operation		Date		Complications			
		Yes	No	Date			
Have you ever had any bleeding problems?							
Have you ever had a blood transfusion?							
MAJOR ILLNESS OR INJURY: list any illness or							
injury requiring hospitalization, prolonged care, or							
use of medication. Include approximate date.							

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Patient Name:					
PERSONAL HABITS/RISK FACTORS					Health Provider Notes
	Yes	No	Answers		Please Don't Write In This Area
Do you smoke or chew tobacco?			pack/	day:	
Have you ever smoked in the past?			Date started:		
			Date stopped:		
Do you often eat 3 meals/day?					
Do you snack regularly?					
Do you diet regularly?					
Do you have an eating problem?					
Any diet preferences/restrictions?					
Type					
Dietary habits			Frequency or No.:		
Low Fat					
No. serving/day vegetables/fruits					
No. servings/day grains					
No. times/week you eat red meat					
No. servings/day dairy					
No. caffeine drinks/day					
Ave. alcoholic drinks/day					
No.of times "drunk"/year					
Ever had a drinking problem?					
Ever had a drug problem?					
Ever used street drugs?			Date last used:		
Do you ever not use seat beat?					
No. hours sleep/day					
Highest grade level achieved					
Do you know how to swim?					
Do you exercise regularly?					
What exercise do you do?					
How often/week?			Duration:		
What do you to relive stress?					
Any pets?					
Any hobbies?					
Occupation:					
Do you like your job?					
Is your job a risk to your health?					
If yes (in any way), please explain:					
Do you have cats?					
Do you change the liter box?					
Do you handle raw meat?					
Do you work with children?					
SOCIAL HISTORY	Do you have children?				
Are you: Married	(step-children, foster children, ect.)				
Separated Single	Yes, please list names & yearborn				
Divorced Widowed					
Living with "signif. other"					

SEXUAL HISTORY	Yes	No	**Lifetime**		
Are you sexually active?			**Sexual Partners**		
Any problems with sex drive?			No. men		
Does sex hurt?			No. women		
Do you bleed after sex?			No. unprotected		
History of Chlamydia?					
Gonorrhea?			How old were you when		
Venereal warts/HPV?			started having sex?		
Herpes?					
Syphilis?					
Are you concerned about AIDS?					
Would you like to have a test?					