Patient Health Forms

All forms MUST be completed and signed prior to seeing the Provider

First: _____ M: ____ Last: _____

Email Address: _____

Home Address: _____

Best Phone Number to Reach You: _____
Last 4 of your social security #: _____

Marital Status (Circle One): Married Single Divorced Separated Widowed Partner

Emergency Contact Information

Name: _____ Relationship to you: _____

Phone Number: _____

Pharmacy Information

Pharmacy Name: _____

Pharmacy Phone Number: _____

Imaging Center

Facility Name: _____

Facility Address: _____

Primary Care Physician

Name: _____

Patient Initial: _____

Health History

Allergies

□ No Allergies

Allergy	Onset Date	Reaction	Severity

Medications

□ No Current Medications

Name of Medications	How do you take Medication? (Oral, Injection, Nasal, Other)	When did you start this Medication ?	How often do you take this Medication?	Dosage?

Immunizations

□ No Vaccinations

□ Flu Vaccine

□ Gardasil Vaccine

□ Tdap (Tetanus, Diphtheria and Pertussis) Vaccine

Patient Initial: _____

Gynecological History

Date of Last Menstrual Period: _____

Date of Last Mammogram: _____

Date of Last Colonoscopy: _____

Date of Last Bone Density: _____

Date of Last Pelvic Ultrasound: _____

Date of Last Pap Smear: _____

HPV Test (Circle One): Positive Negative Not Applicable

HPV Vaccination (Circle One): Completed Not Applicable

History of Abnormal PAP: ☐ Yes ☐ No

History of Cervical Dysplasia: ☐ Yes ☐ No

Sexually Active: ☐ Yes ☐ No

Age at First Intercourse: _____

Total Lifetime Partners: _____

Sexual Orientation (Circle One): Heterosexual Homosexual Bisexual Transgender

History of Sexually Transmitted Infection: ☐ Yes ☐ No

Current Birth Control Method (Circle One): Abstinence Condoms Depo Provera Diaphragm Essure IUD Nexplanon Tubal Ligation Vasectomy- Partner Menopause Hysterectomy Withdrawal None

Age at First Menstrual Period: _____

Age at Menopause: _____

Post-Menopausal Hormone Use (Circle One): Never Past Use Current Use

History of Endometriosis: ☐ Yes ☐ No

History of Fibroids: ☐ Yes ☐ No

History of Infertility: ☐ Yes ☐ No

History of Ovarian Problems: ☐ Yes ☐ No

History of PCOS: ☐ Yes ☐ No

Medication taken for Menses: ☐ Yes ☐ No

Menstrual Cycle Length (days): _____

Patient Initial: _____

Obstetric History

Full Term: _____

Premature: _____

Abortions Induced: _____

Abortions Spontaneous: _____

Ectopics: _____

Multiple Births: _____

Living: _____

Family History *(Please indicate which family member (Maternal/Paternal) next to each selection)*

□ No Diseases or conditions

□ Blood Coagulation Disorder _____

□ Stroke _____

□ Dementia _____

□ Disorder of thyroid gland _____

□ Heart Disease _____

□ High Cholesterol _____

□ High Blood Pressure _____

□ Ovarian Cancer _____

□ Uterine Cancer _____

□ Malignant Neoplastic Disease _____

□ Breast Cancer _____

□ Cervical Cancer _____

□ Colon Cancer _____

□ Lung Cancer _____

□ Pancreatic Cancer _____

□ Osteoporosis _____

Patient Initial: _____

Social History

Smoking Status (Circle One): Never Smoker Former Smoker Current Every Day Current Someday Smoker

Smoking- How Much? _____

Tobacco Years of Use: _____

Alcohol Intake (Circle One): None Occasional Moderate Heavy

Illicit Drugs: □ Yes □ No

Country of Birth:

_____

Ethnic Background:

_____

Education:

_____

Occupation:

_____

Religion:

_____

Marital Status:

_____

Spouse/Partners Name:

_____

Children's Name/DOB:

_____

Domestic Violence: □ Yes □ No

Hobbies/Activities:

_____

General Stress Level (Circle One): Low Medium High

Have you recently (within the last 12 weeks, or during a current pregnancy) traveled to or lived in a zika-affected area? □ Yes □ No

Patient Initial: _____

Do you have symptoms associated with zika virus (fever, rash, joint pain, or conjunctivitis) □ Yes □ No

Surgical History

□ No surgeries

□ Breast- Augmentation

□ Breast- Biopsy

□ Breast- Lumpectomy

□ Breast- Mastectomy

□ Breast- Reconstruction

□ Breast- Reduction

□ Cancer- Surgery

□ Cardio- Heart Surgery

□ Derm-Skin Surgery

□ ENT- Tonsillectomy

□ Endo-Parathyroidectomy

□ Eye- Surgery

□ GI- Abdominal Surgery

□ GI- Appendectomy

□ GI- Cholecystectomy

□ GI- Colon Resection

□ GI- Colonoscopy

□ GI- Hemorrhoid Surgery

□ GI- Hernia Repair

□ GI – Liver Biopsy

□ GYN- Cryotherapy of the Cervix

□ GYN- Cystoscopy

□ GYN- D & C

□ GYN- Ectopic Pregnancy

□ GYN- Endometrial Ablation

□ GYN- Fibroid Surgery

□ GYN- Hysterectomy

□ GYN- LEEP/Cone Biopsy

□ GYN- Labial Abscess I&D

□ GYN- Laparoscopy

□ GYN- Ovarian Surgery

□ GYN- Pelvic Prolapse Surgery

□ GYN- Removal of Both Ovaries

□ GYN- Removal of Left Ovary

□ GYN- Removal of Right Ovary

□ GYN- Tubal Ligation

□ GYN- Tubal Reversal

□ GYN- Urinary Incontinence

□ GYN- Vulvar Surgery

□ Neuro- Back Surgery

□ Neuro- Brain Surgery

Patient Initial: _____

□ GI- Splenectomy

□ GI- Weight Loss Surgery

□ GYN- Abdominal Surgery

□ GYN- Bartholin's Gland Surgery

□ GYN- Bladder Surgery

□ OB- Cerclage

□ OB- Cesarean Section

□ Ortho- Joint Replacement

□ Plastic- Cosmetic Surgery

□ Surgery- Other

Past Medical History

□ No diseases or conditions

□ Cancer-Breast

□ Cancer- Colon

□ Cancer- GYN

□ Cancer- Skin

□ Cancer- Other

□ Cardiac- Heart Disease

□ Cardiac- High Blood Pressure

□ Cardiac- High Cholesterol

□Dermatology- Other

□ ENT- Other

□ Endocrinology- Diabetic History of Gestational Diabetics

□ Endocrinology- Osteoporosis/Osteopenia

□ Endocrinology- Other

□ Endocrinology- Thyroid Problems

□ GI- Colon Polyps

□ GI- Dysplasia

□ GI- Gallbladder Disease

□ GI- Irritable Bowel Syndrome

□ GI- Other

□ GYN-Fibroids

□ GYN- Infertility

□ GYN-PCOS

□ GYN-Other

□ Hematology-Bleeding/ Clotting

□ Hematology DVT Pulm. Embolism

□ Infectious Disease

□ Neurology-Headaches/Migraines

□ Neurology-Other

□ Ortho- Other

□ Psychiatric-ADD

□ Psychiatric-Anxiety/ Depression

□ Psychiatric-Other

□ Psychiatric-PMS/PMDD

□ Pulmonary-Asthma

□ Pulmonary-Other

□ Pulmonary-Seasonal Allergies

□ Rheumatology-Other

□ Urology- Kidney Stones

□ Urology- Other

Patient Initial: _____

□ GI – Reflux/Stomach Ulcers

□ Urology- Freq Urinary Tract Infection

□ GYN- Dysplasia

□ Wt. Mgmt- Obesity

□ GYN- Endometriosis

□ Z-Other

I acknowledge that if the status of any of the above information changes, it will be my responsibility to inform the doctor and staff.

Print Name: _____ DOB: _____

Patient Signature: _____ Today's Date: _____