



## HEALTH HISTORY

Welcome to our practice! To provide you with the best, most comprehensive care possible, we request that you provide the following information. All information is held strictly confidential and is released only with your written permission.

Last Name:

First Name:

Age:

Reason for visit:

Please list all ALLERGIES:

Please list all Medications and dosages

OB/GYN HISTORY	Explanations	
	Yes	No
Date of Last menstrual period		
Age of first menses:		
No. of days between periods		
No. of days periods last		
Spotting between periods?		
Are you menopausal ? If yes since when ?		
Have you ever been pregnant ?		
No. of pregnancies		
No. of live births		
No. of abortions or miscarriages		
Date of last Pap smear		
Was it abnormal?		
Have you ever had any other abnormal Pap?		
Are you currently using contraception?		
Type of contraception		
If over the age of 40, when was your last mammogram?		



<b>SURGICAL HISTORY:</b>	<b>Date</b>	<b>Complications</b>
Name of Operation		
Have you ever had any sexually transmitted infections to include: Gonorrhea, Chlamydia, herpes, or Trichomonas? (If yes, please detail which and when in adjacent column)		
Yes            No		
Has any member of your family ever had the following : (please list relationship in adjacent column)		
Diabetes	Yes    No	
High blood pressure	Yes    No	
Stroke	Yes    No	
Heart Disease	Yes    No	
Breast Cancer	Yes    No	
Cervical Cancer	Yes    No	
Endometrial Cancer	Yes    No	
Ovarian Cancer	Yes    No	
Other Cancers?	Yes    No	
If so what type? _____		

**MAJOR ILLNESS OR INJURY:** list any illness or injury requiring hospitalization prolonged care or use of medication.

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## PERSONAL RISK FACTORS

OB/GYN HISTORY	Yes	No		Answers
Do you smoke or chew tobacco?			No. packs/day:	
Have you ever smoked in the past?			Date started: Date stopped:	
Any diet preferences/restrictions?				
Type				
Dietary habits :				
No. servings/day vegetables/fruits				
No. servings/day grains				
No. times/week you eat red meat				
Mo servings/day dairy				
No. caffeine drinks/day				
Average alcoholic drinks/month				
Have you ever tried illegal drugs or used prescribed drugs in an illegal manner ?				
No. hours sleep/day				
Do you exercise regularly?			Duration	
What exercise do you do?				
How often/week?				
What do you do to relieve stress? Is it effective ?				
Any pets?_				
Any hobbies?				
Occupation				
What is your Marital Status				
What are the first names and ages of your children.				
Are you sexually active?				
Is sex unsatisfactory in any way?				
Are you experiencing any urinary leakage ?				
Are there any other concerns you would like to discuss with Dr. Adams-Pickett today ?				