

New Patient Health History

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

This questionnaire will help your care provider obtain a large amount of information while still being able to focus on your most important concerns. Please answer all questions as best as you can. All answers will be kept confidential.

Current and Past Medical Problems (for example: anemia, asthma, arthritis, bleeding problems, colitis, cancer, high cholesterol, diabetes, hepatitis, high blood pressure, heart attack, depression, epilepsy, glaucoma, kidney problems, urinary tract infections, incontinence, migraines, HIV, thyroid, pneumonia, Valley Fever)

- 1. \_\_\_\_\_ 4. \_\_\_\_\_
2. \_\_\_\_\_ 5. \_\_\_\_\_
3. \_\_\_\_\_ 6. \_\_\_\_\_

Operations and date (for example: cesarean section, D&C, hysterectomy, tonsillectomy, appendectomy, gallbladder, breast biopsy)

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
2. \_\_\_\_\_ 4. \_\_\_\_\_

Medications (list all medications you currently take including prescriptions, birth control pills, cold medicines, herbal remedies, aspirin, vitamins). Please list medication dosage and frequency.

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
2. \_\_\_\_\_ 4. \_\_\_\_\_

Allergies to Medications (all medications that you can not take, or have had a reaction to). Specify type of reaction.

\_\_\_\_\_
\_\_\_\_\_

Social History

Marital status \_\_\_\_\_ Highest level of education \_\_\_\_\_ Occupation \_\_\_\_\_

Hobbies \_\_\_\_\_ Interests \_\_\_\_\_

- 1. Do you smoke cigarettes? O Yes O No If yes, how many per day? \_\_\_\_\_ Do you have a plan to quit? O Yes O No
2. Have you smoked in the past? O Yes O No If yes, how many years and when did you last quit? \_\_\_\_\_
3. Do you drink alcohol? O Yes O No If yes, how many drinks per week? \_\_\_\_\_ Do you drink alone? \_\_\_\_\_
4. Do you use caffeine? O Yes O No If yes, how much? \_\_\_\_\_
5. Have you used illegal drugs? O Yes O No If yes, what type and when \_\_\_\_\_
6. Do you exercise? O Yes O No What type? \_\_\_\_\_ How often? \_\_\_\_\_

7. How much do you weigh? \_\_\_\_\_ 5 years ago? \_\_\_\_\_ 10 years ago? \_\_\_\_\_

8. Do you have risk factors for AIDS or HIV infection such as intravenous drug use, blood transfusion, multiple sexual partners or sexual exposure to a gay or bi-sexual male, exposure to an IV drug user, or have any other reason to believe you may have had AIDS exposure?  
\_\_\_\_\_

9. A. Have you ever been physically or sexually touched without your consent or in a manner which you felt was not right?  
B. Do you feel safe at home?  
\_\_\_\_\_

**Health Maintenance**

Please list date (year) in which you last had any of these procedures. Indicate results if known.

Complete Physical \_\_\_\_\_ PAP smear \_\_\_\_\_ Mammogram \_\_\_\_\_ Cholesterol screen \_\_\_\_\_

Flu shot \_\_\_\_\_ Tetanus shot \_\_\_\_\_ Measles, Mumps, Rubella vaccine \_\_\_\_\_ Hepatitis B Vaccine \_\_\_\_\_

Colonoscopy \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ EKG \_\_\_\_\_ Bone Densitometry \_\_\_\_\_

Have you had chicken pox or have you received the varicella vaccine?  Yes  No  Do not know

**Gynecologic History**

Start date of last menstrual period \_\_\_\_\_ Number of days between periods from start to start \_\_\_\_\_

Length of periods \_\_\_\_\_ Pain with periods  Yes  No Heavy Bleeding  Yes  No Other \_\_\_\_\_

\_\_\_\_\_ Age of menopause \_\_\_\_\_

Number of pregnancies \_\_\_\_\_ # of children \_\_\_\_\_ Miscarriages \_\_\_\_\_ Other (abortions, ectopic, molar pg) \_\_\_\_\_

Complications of pregnancy \_\_\_\_\_

Have you ever had an abnormal PAP smear?  Yes  No If yes, what was the diagnosis and how was it treated?  
\_\_\_\_\_

\_\_\_\_\_ Have you received the HPV vaccine?  Yes  No

Have you ever had gonorrhea, chlamydia, pelvic inflammatory disease, Herpes, or syphilis? If yes, when and where were you treated?  
\_\_\_\_\_

Type of birth control \_\_\_\_\_ Breast self exam  Yes  No Estimated mg of daily calcium \_\_\_\_\_

Pain with intercourse  Yes  No Sexual concerns (libido, orgasm, other) \_\_\_\_\_

**Family History** (Blood relatives)

List family members who have had any of these medical problems: Cancer (type), heart attack, high cholesterol, high blood pressure, diabetes, osteoporosis, sickle cell anemia, cystic fibrosis, kidney disease, asthma, thyroid or other medical problem:

Illness: \_\_\_\_\_ Family Member (s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any other concerns you have related to your past or present health history: