Initial Personal Health Assessment

Today's Date: _____

Name: _____ **Date of Birth:** _____
(Last) (First) (Middle Initial)
Marital Status _____ **Occupation** _____
Primary Care Physician: _____ **Referred By:** _____
What would you like to address at today's visit _____
_____

How did you hear about our office? □ Online search □ Insurance □ Physician □ Family/Friend □ Other

ALLERGIES:
Please note any allergies or reactions to medications or other agents. ❑ None
Allergen and reaction:
_____
_____

CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: ❑ None
Med/Dose/Instruction: _____
Med/Dose/Instruction: _____
Med/Dose/Instruction: _____

OBSTETRIC HISTORY
Have you ever been pregnant? Yes ❑ No ❑ If yes, how many times? _____
How many children do you have _____
Please list all pregnancies (including miscarriages and abortions):

Pregnancy Outcome (vaginal, Cesarean, VBAC, miscarriage, abortion, ectopic)	Date	Weeks of Gestation	Problems or Complications

MENSTRUAL HISTORY
At what age did your periods start? _____ Date of Last Menstrual Period: _____
Menses every: _____ days
Mostly: Regular ❑ Irregular ❑
Lasting ____ days
Flow: Light ❑ Moderate ❑ Heavy flow ❑
Bleeding between menses: Yes ❑ No ❑
Pain with menses: Mild ❑ Moderate ❑ Severe ❑
Current Method of Contraception: _____

SEXUAL HISTORY
Are you currently sexually active? Yes ❑ No ❑ If no, have you ever been sexually active? Yes ❑ No ❑
Are your partner(s): Male ❑ Female ❑ Both ❑
What method(s) of birth control are you using (include condoms and sterilization) _____
Do you or your partner have more than one partner? Yes ❑ No ❑
How many sexual partners have you had in the past year? _____
Do you have concerns about sexually transmitted infections? Yes ❑ No ❑
Do you want to be screened for HIV, or other STD's? No screening ❑ HIV ❑ Other STD screening ❑
Do you have any concerns about sex? Yes ❑ No ❑
Are you planning pregnancy in the next year? Yes ❑ No ❑

LIFESTYLE/PERSONAL HABITS	Yes	No		
Alcohol	❑	❑	Drinks per day: _____	Drinks per week: _____
Marijuana	❑	❑	Days used/week: _____	
Current Drug Use	❑	❑	Type: _____	Days used per week: _____
History of Drug Use	❑	❑	Year of last use: _____	
Current Tobacco Use	❑	❑	Pack per day: _____	Age: _____
History of Tobacco Use	❑	❑	Age quit: _____	
Seat Belt Use	❑	❑		

Describe your diet: ❑Healthy ❑ Average ❑ Poor ❑ Vegetarian/Vegan ❑ Weight Watchers
Describe your exercise: ❑Regularly ❑Occasionally ❑Rarely ❑ Never

Personal Safety	Yes	No
Is there anything in your past that may make your visit today uncomfortable/traumatic/scary?	❑	❑
Have you been emotionally or physically abused by your partner, or someone close to you?	❑	❑
Has anyone ever forced you to have sex or sexual contact?	❑	❑
Are you ever afraid of your partner?	❑	❑
Have you recently felt down, hopeless or had little interest in doing things you enjoy?	❑	❑

PREVENTATIVE CARE

Date of Last Pap: _____

History of Abnormal Paps? ❑ Yes ❑ No Year _____

Have you ever had any of the following STDs?

❑ Chlamydia ❑ Gonorrhea ❑ Trichomonas ❑ HIV ❑ Genital Herpes ❑ Genital Warts ❑ Hepatitis C
❑ Hepatitis B ❑ Syphilis

Do you or have you had the following Gynecologic problems?

❑ Abnormal pap	❑ STI/Sexually Transmitted
❑ DES Exposure (When your mother was pregnant with you)	❑ Pelvic Inflammatory Disease
❑ Endometriosis or Adenomyosis	❑ PMS
❑ Irregular periods	❑ Abnormal Uterine Structure
❑ PCOS	❑ Urine Incontinence
❑ Ovarian Cyst, Type _____	❑ Dysplasia/Precancer: Cervical ❑ Vaginal ❑ Vulvar ❑
❑ Infertility	❑ Recurrent Vaginitis: Yeast ❑ BV ❑
❑ Fibroids	❑ Pain with Sex
❑ Chronic Pelvic Pain	❑ Other _____

Do you have the following medical problems?

❑ Anemia	❑ High blood pressure (Hypertension)
❑ Anxiety	❑ High cholesterol
❑ Arthritis	❑ Kidney infection (Pyelonephritis)
❑ Asthma	❑ Kidney stones
❑ Blood transfusion	❑ Migraines
❑ Cancer, Type _____	❑ Osteopenia
❑ Depression	❑ Osteoporosis
❑ Diabetes	❑ Seizure disorder (Epilepsy)
❑ DVT (Deep venous thrombosis)	❑ Stroke (Cerebrovascular accident)
❑ Endometriosis	❑ Thyroid disorder
❑ GERD (Gastroesophageal reflux)	❑ OTHER medical problems: _____

SURGICAL HISTORY: List all operations (excluding pregnancy): ❑ None

DATE	SURGERY

FAMILY HISTORY: Adopted ❑

Illness	Relation to you	Paternal = P Maternal = M	Details/Comments
Autoimmune Disease (Lupus, ulcerative colitis, RA)			
Heart Disease (heart attack, high blood pressure, high cholesterol			
Cancer - Breast			
Cancer - Colon			
Cancer - Ovarian			
Cancer - Uterine			
Cancer – Other			
Diabetes			
Genetic Disorders (CF, Muscular Dystrophy, Tay Sachs, Fragile X, Thalassemia, Sickle Cell)			
Gynecologic Problem (fibroids, infertility, early menopause, endometriosis)			
Hypercoagulable Disorder (blood clots in legs or lungs)			
Mental Illness/Substance abuse			
Osteoporosis			
Stroke			
Thyroid Disease			
Other			

Immunizations	**No**	**Yes**	**Date Given:**
Flu Shot this flu season			
HPV Vaccine, Dose # 1			
HPV Vaccine, Dose # 2			
HPV Vaccine, Dose # 3			

REVIEW OF SYSTEMS: (please check if you ***currently*** have any of the following symptoms)

❑ Fatigue	❑ Chest pain	❑ Faint
❑ Weight gain	❑ Persistent cough	❑ Dizzy
❑ Weight loss	❑ Shortness of breath	❑ Anxiety
❑ Easy bruising	❑ Wheezing	❑ Depression
❑ Enlarged glands or lumps	❑ Acid reflux	❑ Headaches
❑ Environmental allergies	❑ Nausea or vomiting	❑ Memory loss
❑ Hot flashes	❑ Abdominal pain	❑ Trouble sleeping
❑ Cold intolerance	❑ Abdominal bloating	❑ Varicose veins
❑ Heat intolerance	❑ Constipation	❑ Muscle or joint pain
❑ Excessive hair loss	❑ Diarrhea	❑ Back pain
❑ Excessive hair growth	❑ Painful urination	❑ Breast pain
❑ Skin rash	❑ Urine incontinence	❑ Breast discharge
❑ Changing moles	❑ Abnormal vaginal discharge	❑ Breast lump
❑ Other _____		