Periodic Personal Health Assessment

Today's Date: ________________

Name: ____ **Date of Birth:** _____________________

(Last) (First) (Middle Initial)

Marital Status _________________________ **Occupation** ______________________________________

Primary Care Physician: ________________________________

What would you like to address at today's visit ____

____

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: ____

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	❑	❑		

Have you been emotionally or physically abused by your partner or someone close to you? Yes ❑ No ❑

Describe your diet: ❑Healthy ❑ Average ❑ Poor ❑ Vegetarian/Vegan ❑ Weight Watchers

Describe your exercise: ❑Regularly ❑Occasionally ❑Rarely ❑ Never

Do you or have you had the following Gynecologic problems?

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

MEDICAL/SURGICAL HISTORY: Since your last exam here, have you had any major health problems or surgery?
No ❑ Yes ❑ Explain: ____

FAMILY HISTORY: Please note any changes in the health of your family since your last visit: ❑ None
____

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