Health History

NAME:_____ **DOB:**_____

The following information is very important to your health. Please take the time to fully and completely fill out this important information. We are counting on you!

Internist or Family doctor: _____

Childhood Illnesses (circle all that apply): measles, rubella, mumps, whooping cough, chicken pox, rheumatic fever, scarlet fever, polio, other _____

Personal History of Adult Illnesses (check all that apply):

- ☐ Arthritis
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Blood Clots
- ☐ Circulation Problems
- ☐ Heart Murmur
- ☐ TIA or Stroke
- ☐ Cholesterol Problems
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Peptic Ulcer Disease
- ☐ Alcoholism
- ☐ Liver Disease
- ☐ Colon Polyp
- ☐ Depression
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Positive PPD (TB skin test)
- ☐ Blood transfusion
- ☐ Anemia
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Anxiety/Panic Disorder
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ MRSA
- ☐ Other: _____

_____

Operations:

Procedure	Year	Hospital	Surgeon

Hospitalizations (not including pregnancies):

Reason	Year	Hospital	Physician

Medications (include nonprescription drugs and vitamin/mineral supplements):

_____ _____

_____ _____

_____ _____

Medication Allergies: _____

_____

_____

_____

Pregnancies	Full Term	Premature	Miscarriages	Abortions	Ectopics	Mult.Births	Living

Date of Birth	Sex	Weight	Type of Delivery	Complications

Are your periods: Regular ____ Irregular ____ Menopause ____ Not Sure ____
Explain:_____

Contraception: Current _____ Past _____

***Abnormal* Pap smear?** □ Yes □ No When?: _____ Treatment: _____

Have you ever had: □ Chlamydia □ Gonorrhea □ Genital Warts □ Herpes
□ Trichomonas □ Syphilis □ HIV □ Hepatitis

Marital Status: □ Married □ Single □ Divorced □ Significant other

Education: □ High School □ College □ Some College Other : _____

Have you ever been in a relationship in which you were hurt, threatened, or made to feel afraid?
□ Yes □ No Explain: _____

Smoke? □ None □ Used to □ Currently Amount _____
Alcohol? □ None Drinks per week _____
Caffeine? □ None Drinks per day _____

Dietary restrictions or supplements: _____

Abnormal screening tests (mammograms, cholesterol, colon, PPD): _____
_____

Exercise and leisure activities: _____

Family History- (circle all that apply)
Diabetes, Heart Disease, Cholesterol Problems, High blood pressure, Circulation Problems, Colon Cancer, Breast Cancer, Ovarian Cancer, Melanoma, Stroke, Kidney Disease, Tuberculosis, Cancer, Arthritis, Osteoporosis, Anemia, Depression, Suicide, Mental Illness, Alcoholism, Drug Addiction.

Age and health or age and cause of death of: parents, siblings, spouse, children:
_____ _____
_____ _____

It is my responsibility to keep Women's Collaborative Care updated to changes in my health history.

Signature: _____ **Date:** _____
The above information is true and correct to the best of my belief.