

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):

- | | | |
|---|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema/COPD |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> TIA or Stroke |
| <input type="checkbox"/> Cholesterol Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Peptic Ulcer Disease | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Colon Polyp | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Positive PPD (TB skin test) | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Anxiety/Panic Disorder | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> MRSA | | |
| <input type="checkbox"/> 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 Chesapeake Women's Health updated to changes in my health history.

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