

**PERSONAL HEALTH & HISTORY INVENTORY**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Race : \_\_\_\_\_ Religion: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Current contraceptive use: \_\_\_\_\_

(THIS IS PART OF YOUR MEDICAL RECORD AND IS KEPT ABSOLUTELY CONFIDENTIAL)

**PERSONAL MEDICAL HISTORY (Please circle and indicate if you have ever had the following)**

	Y / N	Date		Y/N	Date		Y/N	Date
Asthma			Eating Disorder			Bowel Problems		
Pneumonia/Lung Disease/Tuberculosis			Collagen Vascular Disease (Lupus)			Arthritis/Joint pain/ Back Problems		
Abnormal Pap Smear /HPV			Glaucoma/Cataracts			Osteoporosis		
Sexually Transmitted Disease			Cancer			Broken Bones		
HIV/AIDS			Seizures/ Epilepsy			Liver Disease/Hepatitis		
Diabetes			Depression/Anxiety			Thyroid Disease		
High Blood Pressure			Anemia			Heart Attack/Problems		
Stroke			Blood Transfusion			Kidney Infections/Stones		
Rheumatic Fever			Reflux/Hiatal Hernia/ Ulcers			Blood Clots in Lungs or Legs		
Chicken Pox			Breast Cancer			Other		

**PLEASE LIST ANY:**

**Medications you take:**  
(include hormones, vitamins, herbs, Non-prescription drugs AND DOSAGE)

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

**Allergies you have:**  
(Includes drug,vaccines, chemicals or other agent reactions)

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

**Surgeries you have had: Include Dates**  
(Including any appendix, gallbladder, tonsils, hernia, spine, breast, ovary, testes, uterus, D&C or other)

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

**FAMILY MEDICAL HISTORY:** (check box if any blood relative has ever had or been treated for the following and indicate which of the following relatives: grandparents, Aunts, Uncles, Mother, Father, Sister, Brother, Children.)

	Yes	Relation	Age		Yes	Relation	Age
Diabetes				Breast Cancer			
Stroke				Colon Cancer			
Heart Disease				Ovarian Cancer			
Blood Clot in lungs/legs				Uterine Cancer			
High Blood Pressure				Birth Defect			
Osteoporosis				Drinking/Drug Problem			
Hepatitis				Mental Illness			
HIV/AIDS				Alzheimer's disease			

**Prevention/Screening:**

**Immunizations:**

Have you had?	Yes	No	Date	Have you had?	Yes	No	Date
Barium Enema				Hepatitis B Vaccine			
Cholesterol Panel				Influenza-flu shot			
Colonoscopy/Sigmoidoscopy				Lyme Disease			
DEXA (Bone Density Scan)				Mumps/Mumps/Rubella			
Heel Ultrasound				Pneumonia shot			
Mammogram				Tetanus			
Do you do self breast exams?				Booster			
Pap Smear				Varicella (Chicken Pox)			
Rubella Titer							

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Check any of the following symptoms you are currently experiencing:**

Weight loss/Weight gain	Nausea/Vomiting/Indigestion	Muscle weakness
Fatigue	Blood in urine	Dry skin
Change in height	Frequent urination	Pain in Breast
Change in vision	Painful urination	Nipple discharge
Glasses/Contacts	Strong urgency to Urinate	Breast lump
Ringling in Ears	Involuntary loss of urine	Dizziness
Sinus Problems	Abnormal vaginal bleeding	Seizures
Sore throat	Painful periods	Frequent/Severe headaches
Mouth sores	Premenstrual Syndrome (PMS)	Depression/anxiety
Shortness of breath	Painful intercourse	Hair loss
Spitting up blood	Fibroids	Abnormal hair growth
Chronic cough	DES Exposure	Heat/Cold intolerance
Frequent diarrhea	Abnormal vaginal discharge	Abnormal thirst
Bloody stool	Muscle or Joint pain	Hot flashes
Cuts that do not stop bleeding	Enlarged lymph node	Other:

**PREGNANCY HISTORY (include any miscarriages, abortions and any ectopic pregnancy)**

	Number		Number		Number
Pregnancies		Abortions		Miscarriages	
Premature births (<37 weeks)		Live births		Living children	

#	Birthdate	Baby's sex	Weeks pregnant	Type of delivery Vaginal or Cesarean	Complications
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

**PREVENTIVE HEALTH:**

YES	NO	
		Do you smoke? For how long: _____ Packs per day: _____
		Do you use caffeine? How many per day? Coffee: _____ Tea: _____ Soft drinks: _____
		Do you drink alcoholic beverages? Daily: _____ Weekend: _____ Only occasionally: _____
		Have you ever had a problem with substance abuse? (prescription or street drugs)
		Do you habitually use laxatives? How long? _____
		Have you ever been physically or sexually abused? Have you or are you currently receiving assistance or Treatment for this [ ] Yes [ ] No Do you need a referral for treatment? [ ] Yes [ ] No
		Have you ever lived in a foreign country?
		Do you exercise regularly? How many times per week? _____ How long per session? _____
		Do you ride a bike? If yes do you wear a helmet? [ ] Yes [ ] No
		Do you use seat belts regularly?
		When in the sun, do you use sunscreen with SPF adequate to exposure time?
		Are you on any special diet? If so, please explain: _____

**OFFICE USE ONLY**

<b>Date reviewed</b>	<b>Initials</b>	<b>Date reviewed</b>	<b>Initials</b>	<b>Date reviewed</b>	<b>Initials</b>

