# Confidential Health History Form

VALLEY WOMENS HEALTHCARE MEDICAL GROUP

**Wade Dickinson, M.D.**

**Name:** _____ **DOB:** _____ **Date:** _____

| Yes | No | | |
|---|---|---|---|
| | | Do you take prescribed medications? | **List:** _____ |
| | | Are you allergic to any medications? | **List:** _____ |
| | | Are you adopted? | |

**FAMILY HISTORY:** Do your Parents, brothers, sisters, or children have any of the following? If yes, who?

| Yes | No | Condition | Who? | Yes | No | Condition | Who? |
|---|---|---|---|---|---|---|---|
| | | Alcohol/Drug Abuse | | | | Mental Illness | |
| | | Arthritis | | | | Heart Attack | |
| | | Severe Anemia | | | | High Cholesterol | |
| | | Bleeding Problems | | | | Stroke | |
| | | Diabetes | | | | Birth Defect/Genetic Problems (Such as: sickle cell anemia, PKU, Tay Sachs) | |
| | | Cancer: What Kind? | | | | | |
| | | High Blood Pressure | | | | | |

**MEDICAL HISTORY:** Have you had problems with:

| Yes | No | Symptom | Comments | Yes | No | Symptom | Comments |
|---|---|---|---|---|---|---|---|
| | | Allergies: To What? | | | | Black or bloody stools | |
| | | Skin | | | | Kidney | |
| | | Eyes/Vision (except glasses) | | | | Holding urine / dribbling | |
| | | | | | | Bladder infection | |
| | | Ears/hearing | | | | Gonorrhea, syphilis, herpes,warts | |
| | | Mouth/teeth | | | | | |
| | | Bleeding or clotting (not with your period) | | | | HIV | |
| | | | | | | Bone injuries: broken bones | |
| | | Anemia | | | | Back pain | |
| | | Cancer: what kind? | | | | Joint problems: arthritis | |
| | | Diabetes | | | | | |
| | | Thyroid disease | | **Have you had any of the following shots:** | | | |
| | | Headaches | | **Yes** | **No** | **Vaccine** | |
| | | Seizures/epilepsy | | | | TDaP | |
| | | Psychiatric problems | | | | Rubella (German Measles) | |
| | | Suicidal depression | | | | Polio | |
| | | High cholesterol | | | | Hepatitis A | |
| | | Heart disease / problem | | | | Hepatitis B | |
| | | High blood pressure | | | | Gardasil | |
| | | Asthma | | | | | |
| | | Tuberculosis | | **Yes** | **No** | **Symptom** | |
| | | Other lung disease | | | | Vaginal infection | |
| | | Positive PPD (skin test for TB) | | | | Pelvic infection (PID) | |
| | | Breast: lump/tumor/ discharge/surgery | | | | Pelvic tumor/fibroid | |
| | | | | | | Abnormal pap? | Date: _____ |
| | | Gall bladder or stones | | | | Mammogram ? | Date: _____ |
| | | Liver disease/hepatitis/ jaundice/mono | | **HOSPITALIZATIONS/SURGERIES: (List all except pregnancy)** | | | |
| | | Stomach | | Year ____ Reason: _____ | | | |
| | | Chicken Pox | | Year ____ Reason: _____ | | | |
| | | Parasites | | Year ____ Reason: _____ | | | |
| | | Ulcer | | Year ____ Reason: _____ | | | |

**Staff Use Only**
**Comments/ Updates**

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**Wade Dickinson, M.D.**

**Name:** _____ **DOB:** _____ **Date:** _____

## MEDICAL HISTORY (Cont.)

| Yes | No | Question | | Explain/Details |
|---|---|---|---|---|
| | | Do you take street drugs? | If so, List them | |
| | | Do you smoke cigarettes? | If so, # cigarettes/Day and How Long? | |
| | | Do you drink alcohol? | If so, # drinks/day and Per/Week | |
| | | Do you consider yourself to have (had) a problem with drugs or alcohol? | | Explain: |

| Yes | No | Question | Explain/Details |
|---|---|---|---|
| | | Are you working? | |
| | | Are you exposed to dangerous chemicals in your work? If Yes, Explain | |
| | | Do you consider your diet healthy? | |
| | | Do you ever make yourself vomit after eating or do you take laxatives to lose weight? | |
| | | Do you exercise? What type? How many times a week? | |
| | | Do you have intercourse? If yes, what age did you begin? | |
| | | Have you had sex with another person in recent months? | |
| | | Number of sex partners in the last 6 months? Male, Female, or Both? | |
| | | Do you use condoms? How often? (Always, Sometimes, Never) | |
| | | Does your partner have other sexual partner(s)? | |
| | | Are you currently, or have you ever been, in a relationship where you were threatened or made to feel afraid? | |
| | | Have you ever been hit, kicked, slapped, pushed or shoved by your partner? | |
| | | Have you ever been forced or pressured to engage in sexual activity when you did not want to? | |
| | | Have you ever been raped? | |
| | | What questions do you have about sex? | |

## Menstrual History

| Yes | No | | |
|---|---|---|---|
| | | Is this your first pelvic exam? | |
| | | Age period started: | |

Periods are (circle all that apply): Regular, Irregular, Painful, Light, Moderate, Heavy

Periods come every _____ Days, and last _____ Days.

Do you have bleeding between periods? (circle one) Yes / No / Sometimes

First Day of Last Menstrual Period: _____

Date of Last pregnancy or birth: _____

| Yes | No | |
|---|---|---|
| | | Are you breast feeding? |

## Pregancy History

| Number of: | |
|---|---|
| _____ | Abortions |
| _____ | Miscarriages |
| _____ | Still Births |
| _____ | Cesareans |
| _____ | Ectopic Pregancies (tubal) |
| _____ | Premature Births |
| _____ | Normal Vaginal Pregnancies |
| _____ | **Total # of Pregnancies** |
| _____ | Age at first pregnancy |

Complications and/or comments on these pregnancies:

## Birth Control History

If you use birth control, what methods have you used?

| | |
|---|---|
| | **Pills** If pills, what kind have you used? _____ |
| | **Depo Injection** |
| | **Diaphragm/Cervical Cap** |
| | **Foam, Suppositories, Cream, Jellies** |
| | **Condoms, Rubbers** |
| | **Withdrawl or pulling out** |
| | **Rhythm, Calendar, or Natural Family Planning** |
| | **Norplant/Nexplanon** |
| | **IUD** |
| | **Tubal Ligation (sterilization)** |
| | **None** |

**Current Birth Control Method:** _____

**I want to change my method to:** _____

**List any problems with these methods:** _____

**Patient/Responsible Party Signature** **Date**

**Clinician/Physician Signature** **Date**