WOMEN'S MEDICAL CENTER

Health History Form

Name: _____ **DOB**: _____ **Age**: _____

Marital Status:_____ **Occupation:** _____

Highest Grade Finished: _____ **Ethnicity (please circle)**: African American Caucasian Hispanic Asian American Native American Ashkenazi Jewish Other: _____

Religion (please circle): Christian Baptist Latter-day Saints Catholic Lutheran Mormonism Judaism Islam Buddism Hinduism Muslim Non-Religious Atheist

Do you exercise? Yes No If yes, what type of exercise? _____

Have you ever been sexually active? Yes No **Are you currently sexually active?** Yes No

Partners: Male Female Both **Do you practice safe sex?** Yes No

What type of contraception do you use:_____

Do you smoke? Yes No **Do you drink alcohol?** Yes No **Do you use Medical Marijuana?** Yes No

Have you ever used any type of illegal drugs? Yes No Type:_____

Do you wear your seatbelt: Yes No **Do you feel safe at home:** Yes No

Do you have Advance Directives: Yes No **Do you want information about Advance Directives:** Yes No

Have you recently had the following vaccines: HPV/Gardasil Flu Pneumonia Shingles Tetanus

Your Personal History (please check all that pertain):

Asthma/Lung Disease		Diabetes		Fracture			Sexual Issues	
Bleeding Disorders		Gallstones		Kidney Disease			Thyroid Disease	
Breast Cancer		Genital Herpes		Liver Disease			Urinary Issues	
Cervical Cancer		Heart Disease		Lupus/Autoimmune			Uterine Cancer	
Colon Cancer		Hematological Disease		Ovarian Cancer				
Depression/Mental Disease		High Blood Pressure		Pelvic Infection/STD				

Family History (list family member):

Alcohol/Drug Abuse_____; Bleeding/Blood Clots_____;
Breast Cancer_____; BRCA Mutation; Cancer Syndrome_____;
Colon Cancer_____; Diabetes_____;
Heart Disease_____; Ovarian Cancer_____;
Other_____

Menstrual History:

Menstrual History: Age of first period _____ Regular? Yes No Cycle length _____
# of bleeding days_____
First day of last menstrual period_____
# of Pregnancies Total _____ # Live Births _____ # Miscarriages _____
Date of last pap smear _____ History of abnormal pap smear: Yes No
Treatment for abnormal pap smear:_____
Date of last mammogram:_____

Name:_____ **Date:**_____

Name of Pharmacy:_____

Allergies

Medication Allery & Reaction	Food Allergy & Reaction	Environmental Allergy & Reaction

Prescription Medications (including Medical Marijuana)

Medication Name	Dose	Frequency	How long have you taken?	Prescriber

Over-The-Counter Medications (include all pills, liquids, topical creams, etc)

Medication	How often	Used for?

Surgical History

Date	Type