Freeman OBGYN Associates Health History

Name:_____ Date:_____

Birthdate:_____ Age:_____ Date of Last Physical:_____

Date of last Pap Smear:_____(normal/abnormal) Date of last Mammogram:_____(normal/abnormal)

Occupation: _____ or (please mark one) ◉**Retired** ◉**Disabled** ◉**Homemaker** ○**Student**

Primary Care Physician:_____

What is the reason for today's visit?_____

MEDICATIONS: List any medications you are currently taking, including dosage:		
1.	2.	3.
4.	5.	6.
7.	8.	9.

Pharmacy_____

ALLERGIES or ADVERSE REACTIONS to Medications or Substances:	
DRUG/SUBSTANCE	***TYPE OF REACTION***

Immunizations:	*Date Received:*
Tdap/Tetanus	
Flu	
Gardasil	

SOCIAL HISTORY:

☐ Married ☐ Living with partner ☐ Single ☐ Widowed ☐ Divorced

Are you sexually active? **Y / N** Do you use birth control? **Y / N** If yes, what type?_____

Partners are(please circle): Male/Female/Both Number of partners(lifetime):_____

Tobacco Use: **Y/N** If yes, what type and how often?_____

Alcohol Use: **Y/N** If yes, what type and how often?_____

Drug Use: **Y/N** If yes, what type and how often?_____

Menstrual History :

First day of your last period:_____ Age when period first began:_____ Cycle Length:_____

How many days does your period typically last:_____(days) Age when Menopause began:_____

PREGNANCY HISTORY (include miscarriage, abortion, etc.)

Date MM/DD/YY	Weeks	Vaginal / C-Section	Complications (if any)	Location of Delivery	M/F	Birth Weight	Name

Hospitalization History:

YEAR	HOSPITAL	REASON FOR HOSPITALIZATION

SYMPTOMS: Check (✓) symptoms you currently have or have had in the past year

☐ Weight loss	☐ Urinary incontinence	☐ Wheezing	☐ Diabetes	☐ Vision Changes
☐ Weight gain	☐ Abnormal Periods	☐ Cough	☐ Muscle Pain	☐ Glasses/contacts
☐ Fever	☐ Vaginal discharge	☐ Indigestion	☐ Joint Pain	☐ Mouth ulcers
☐ Fatigue	☐ PMS Symptoms	☐ Bloody stool	☐ Dark colored spots/moles	☐ Sinusitis
☐ Breast pain	☐ Dyspareunia	☐ Constipation	☐ Dry Skin	☐ Hearing loss
☐ Masses/Lumps	☐ Dysuria	☐ Hemorrhoids	☐ Numbness	☐ Hives
☐ Nipple discharge	☐ Edema	☐ Diarrhea	☐ Fainting spells	☐ Seasonal Allergies
☐ Urinary frequency	☐ Palpitations	☐ Abdominal Pain	☐ Seizures	☐ Easily bruised
☐ Urinary urgency	☐ Chest pain	☐ Heat/Cold Intolerance	☐ Anxiety	☐ Bowel Habit Changes
☐ Hematuria	☐ Shortness of breath	☐ Hair Loss	☐ Depression	☐ Excessive Bleeding

PAST MEDICAL HISTORY

☐ Abnormal Pap	☐ Autoimmune Disease	☐ Domestic Violence	☐ Infertility	☐ Liver Disease
☐ Allergic Rhinitis	☐ Bleeding disorder	☐ DVT	☐ Epilepsy	☐ Lupus
☐ Anemia iron deficiency	☐ Congenital heart disease	☐ Endometriosis	☐ Headaches	☐ Osteoporosis
☐ Anesthesia Complication	☐ COPD	☐ Genital Warts	☐ Heart Disease	☐ Phlebitis
☐ Anxiety	☐ Valvular Heart disease	☐ HIV	☐ Hyperlipidemia	☐ Seizures
☐ Depression	☐ Varicose Veins	☐ Herpes- genital	☐ Hypertension	☐ Stroke
☐ Bipolar disorder	☐ Diabetes, type 1	☐ Hepatitis B	☐ Hyperthyroidism	☐ TB
☐ Schizophrenia	☐ Diabetes, type 2	☐ Hepatitis C	☐ Hypothyroidism	☐ Uterine Anomaly
☐ Postpartum depression	☐ Breast Cancer	☐ Hepatitis	☐ IBS	☐ Urinary Tract Infection
☐ Psychiatric care	☐ Cervical Cancer	☐ Pelvic Pain	☐ Kidney Disease	☐ Pulmonary Embolism
☐ Asthma	☐ Cancer,other_____	☐ STD_____	☐ Fractures _____	☐ Other_____

PAST SURGICAL HISTORY-- Please list a date if known:

☐ None	☐ Hysteroscopy	☐ Right Mastectomy	☐ Gastric Bypass
☐ Abnormal PAP Surgery	☐ Incontinence Surgery	☐ Left Mastectomy	☐ Hernia Repair
☐ C-Section	☐ Laparoscopy	☐ Mastectomy- bilateral	☐ Hip Replacement
☐ Cervical Conization	☐ LEEP	☐ Breast Reconstruction	☐ Knee Replacement
☐ Colporrhaphy	☐ Myomectomy	☐ Breast Augmentation	☐ Knee Surgery
☐ Cryosurgery	☐ Oophorectomy (ovaries)	☐ Breast Reduction	☐ Shoulder Surgery
☐ D & C	☐ Salpingectomy(fallopian tubes)	☐ Appendectomy	☐ Tonsillectomy
☐ Ectopic Pregnancy	☐ Tubal Ligation	☐ Back Surgery	☐ Wisdom Teeth
☐ Endometrial Ablation	☐ Tubal Reversal	☐ Carpal Tunnel	☐
☐ Essure Tubal Occlusion	☐ Uterine Artery Embolization	☐ Cataract Surgery	☐ Other_____
☐ Hysteroscopy	☐ Breast Biopsy	☐ Cholecystectomy (gallbladder)	☐ Other_____
☐ Incontinence Surgery	☐ Breast cyst Aspiration	☐ Cosmetic Surgery	☐ Other_____
☐ Hysterectomy(type)_____	☐ Lumpectomy	☐ Foot Surgery	☐ Other_____
			☐ Other_____

FAMILY HISTORY: Please write the family member that history applies.

Alcoholism	CHD Female <55	Hypertension	Seizures
Arthritis	Colon Cancer	Hyperlipidemia	Stroke
Asthma	Colon Polyps	Kidney Disease	Suicide
Bleeding disorder	Depression	Lung Cancer	Thyroid Disease
Breast Cancer	Diabetes	Other Cancer	Uterine Cancer
Cervical Cancer	Endometriosis	Osteoporosis	Weight Disorder
Coronary Heart Disease	Chronic Headaches	Ovarian Cancer	Other
CHD Male<55	Heart Disease	Psychiatric Care	

*Patient Signature:*_____ *Date:*_____

*Provider Signature:*_____ *Date:*_____