



**INITIAL HEALTH HISTORY AND
ASSESSMENT**

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Name: _____ **Birth date:** _____ **Today's date:** _____
Last First Middle mo / day / yr mo / day / yr

Phone number: Home: _____ **Work:** _____ **Age:** _____ **Primary Care Provider:** _____

Why are you coming to the Center today? _____

Past Medical and Family History

For yourself, provide details and dates. For family members, please check if yes.

	Self	Mother	Father	Siblings	Children	Other
Stroke						
Heart Disease						
Hypertension						
High Cholesterol						
Asthma/emphysema						
Thyroid disease						
Diabetes						
Cancer Type						
Alcoholism						
Drug Abuse						
Osteoporosis						
Arthritis						
Heartburn/ulcer						
Bowel problems						
Depression / Anxiety						
Hepatitis						
Eating Disorders						

Other health issues? _____

List any surgeries you have had

Description	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



OC1202



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Patient Identification

Gynecologic / Obstetric History

Age of first period _____
Date of last menstrual period ____/____/_____
How many days between periods (average)? _____
How long do periods last? _____
Bleeding between periods? Yes No
Bleeding after menopause? Yes No
Are periods too heavy/too painful? Yes No
Contraception? Yes No Type: _____
Are you sexually active? Yes No
With: Man Woman Both
Do you have sexual concerns? Yes No
Is intercourse painful? Yes No
New sexual partner in the last year? Yes No

Number of lifetime sexual partners:
less than 5 5 or more
Number of pregnancies _____
Vaginal deliveries _____
C-sections _____
Miscarriages _____
Abortions _____
Date of Last Pap: ____/____/_____
History of abnormal Pap smears? Yes No
History of sexually transmitted infections? Yes No
If so, type(s) _____
History of sexual or physical abuse? Yes No
Current sexual or physical abuse? Yes No
Do you perform self breast exams? Yes No

Current medications (prescribed or over the counter) / supplements / herbs

<u>Medication / Dose</u>	<u>Medication / Dose</u>	<u>Medication / Dose</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List allergies to medications including reaction

<u>Medication / Reaction</u>	<u>Medication / Reaction</u>
_____	_____
_____	_____

Social history and habits:

Single Partnered Married Divorced / separated Widowed
Do you work outside the home? Yes No
What is your occupation? _____
Do you have children? Yes No Ages _____
Do you exercise? Yes No Type/frequency _____
Alcohol use: Yes No Amount per day/week _____
Tobacco use: Yes No Past use: Yes No
cigarettes per day _____ Age began _____ Age quit _____
Drug use: Yes No Type: _____



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Do you have any of the following symptoms currently?

- | | |
|--|--|
| <input type="checkbox"/> Abdominal or pelvic pain | <input type="checkbox"/> Visual / hearing problems |
| <input type="checkbox"/> Constipation / diarrhea / blood in stool | <input type="checkbox"/> Weight loss, fevers, chills, sweats |
| <input type="checkbox"/> Heartburn / trouble swallowing | <input type="checkbox"/> Headaches – migraine or tension |
| <input type="checkbox"/> Urine leakage | <input type="checkbox"/> Numbness / tingling / weakness of extremities |
| <input type="checkbox"/> Vaginal / vulvar itching, irritation, discharge | <input type="checkbox"/> Joint / muscle pain |
| <input type="checkbox"/> Breast lumps / nipple discharge | <input type="checkbox"/> Depression, anxiety, irritability, trouble sleeping |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hot flashes / vaginal dryness |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Other concerns? _____ |

Screening/Health Maintenance

RESULT

	Date of last exam/immunization	Normal	Abnormal
Pap Smear			
Mammogram			
Bone Density Exam			
Cholesterol Test			
Diabetes Test			
Thyroid Test			
Self Breast Exam			
Colon Cancer Screening			
Stool cards			
Flexible Sigmoidoscopy			
Colonoscopy			
Barium enema			
Immunizations			
Tetanus			
Hepatitis A			
Hepatitis B			
Measles/Mumps/ Rubella			
Influenza			
Pneumonia			

Assessment Completed by: _____ **Date:** _____

