Suncoast OB/GYN All Women's Midwifery & Health Care

Health History

Patient Name: _____ **Age:** _____

Reason for visit: _____

Please answer ALL questions to the best of your ability. If you are unsure of the answer, leave it blank.

Medications/Herbal Remedies or Vitamins: (name, dosage and directions-please be specific-you can attach a separate list)

_____ _____

_____ _____

_____ _____

Medical History (only yours):

Asthma/Lung Disease	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No
Bleeding/Clotting Disorder	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Autoimmune Disorder	☐ Yes ☐ No
Psychological Disorder	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Glandular Disorder	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Osteopenia	☐ Yes ☐ No	Neurological Disorder	☐ Yes ☐ No
Atrial Fibrillation	☐ Yes ☐ No	Dehydration	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Heart Failure	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Thyroid Disorder	☐ Yes ☐ No	Hepatitis/Liver Disease	☐ Yes ☐ No

Other_____

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If you answer yes to any of the above questions, please explain. Include date, treatment received and if available the following physician _____

_____

_____

Allergies: ☐ Yes ☐ No Known Drug Allergies (if **Yes**, please specify below)

Medication/Dosage/Reaction:

_____ _____ _____

_____ _____ _____

Environmental/Food Allergies:

_____ _____ _____

_____ _____ _____

Have you had a blood transfusion? ☐ Yes or ☐ No If Yes: When? _____

Past GYN History

Last Pap: Normal/Abnormal (circle)	**Sexually Active:** Yes / No (circle)
Last Mammogram:	**Your Partners :** Male / Female / Both (circle one)
Age of 1st Period:	**Birth Control Method:**
Last Menstrual Period:	**Age at Menopause:**
Length of periods (days):	**Bone Density:** Yes / No **If yes when:**
Cramps? Mild / Mod / Severe / None (circle)	**Have you ever had an STD?**
Number of days between Periods:	**Experiencing Incontinence:** Yes / No

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Pregnancy History

Past OB History	Number of pregnancies	Dates	Complications	Weeks's Gestation	Newborn Weight	Anesthesia Y/N
Vaginal Delivery						
C-section						
Miscarriage						
Abortion						
Still Birth						

Menstrual History

First day of Last Period: _____ Age of First Period: _____

Are your Periods Regular? ☐ Yes ☐ No ☐ Only on Pill

How Many Days Between Periods: _____ Length of Period: _____

Surgical History: (what type of surgery and when)

_____ _____

_____ _____

Hospitalizations: (which hospital, when and the reason for admission/ER visit)

_____ _____

_____ _____

Specialists: (name of physician and condition treated)

_____ _____

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Family History:

	Diabetes	High BP	Heart Attack	Heart Disease	Lung Cancer	High Cholesterol	Asthma
Mother							
Father							
	Breast Cancer	Ovarian Cancer	Uterine Cancer	Colon Cancer	Osteoporosis	Other	
All Family							

Social History:

Caffeine (drinks or caffeine containing drugs) ☐ Yes / ☐ No If Yes: How Much? _____

Tobacco ☐ Yes / ☐ No If Yes: How much per day? _____ How long used? _____

Alcohol ☐ Yes / ☐ No If Yes: How much per day? _____ How long used? _____

Drug Use (illicit or non-prescribed) ☐ Yes / ☐ No If Yes: How often? _____ What type? _____

Domestic Abuse ☐ Yes ☐ No If Yes: ☐ Past or ☐ Present (please circle)

****If there is additional testing required we will send the test to an outside lab and you will receive a separate invoice. If you have questions regarding the testing, please ask the Nurse or your provider. Thank you!**

Patient (or Responsible Party) Signature: _____

Date: _____