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Riverside GYN

HEALTH HISTORY UPDATE

SURGICAL HISTORY

Please list any surgeries you have had	Date(s)

MEDICATION HISTORY

Medications currently taken on a regular basis (including any over-the-counter medications, Vitamins, and herbal supplements):

Name of Medication	I take this for (High BP, etc)	Dosage (i.e., 10 mg)	Amount/ # of tablets daily (two tablets twice a day)

ALLERGIES:

Including medications, latex, foods, ect.	Reaction is: ("rash", "hives", "shortness of breath" etc)

PAST MEDICAL HISTORY

	Check One	Notes
Anemia or Blood Disorder	□Yes □No	
Birth defects or inherited disease	□Yes □No	
Bone Fracture	□Yes □No	
Breast problem	□Yes □No	
Cancer (If yes, please specify in the notes field)	□Yes □No	
Cholesterol Problems	□Yes □No	
Convulsions or Fainting	□Yes □No	
Depression	□Yes □No	
Diabetes	□Yes □No	
Ear Problems	□Yes □No	
Eye Problems	□Yes □No	
GI Problems	□Yes □No	
Heart Condition	□Yes □No	
Hepatitis	□Yes □No	
High blood pressure	□Yes □No	
Hyperthyroidism	□Yes □No	
Hypothyroidism	□Yes □No	
Kidney or Bladder Problems	□Yes □No	
Lung Disorder or Asthma	□Yes □No	
Nose or Throat Problems	□Yes □No	
Varicosities	□Yes □No	
Other significant conditions: (*please indicate)* ____ ____	□Yes □No	

SOCIAL HISTORY

Occupation						
Highest Education						
Exercise type and Frequency						
Alcohol Intake per week						
Alcohol- years of use	10+ years	5-10 Years	2-5 Years	1 Year	<6 Months	
Smoking (Packs per day/Week)	None	>5 PPD	2-4 PPD	1-2 PPD	1-2PPW	<1PPW
Tobacco-years of use	10 + Years	5-10 Years	2-5 Years	1 Year	<6 Months	
History of/ or current abuse	Yes	No	Notes:			
Are you safe	Yes	No				
Race						
Notes:						

FAMILY MEDICAL HISTORY

Relationship	Problem	Onset age	Deceased from condition? What age?
			□Yes □No Age _________
			□Yes □No Age _________
			□Yes □No Age _________
			□Yes □No Age _________
			□Yes □No Age _________

GYN HISTORY

				Notes:
Sexual Orientation	Heterosexual	Homosexual	Bisexual	
Last Menstrual Period	Date:			
Frequency of Cycle (Q days)				
Flow	Light	Moderate	Heavy	
Duration of Flow (days)				
Age of Menopause, if applicable				
Abnormal bleeding	Post-Coital	Post-Menopausal	Between Cycles	
PMS	Yes	No		
Menstrual Cramps	Yes	No		
Contraception Method				
Sexual Dysfunction	Decreased Libido	Pain with intercourse	Arousal Difficulties	
Date of Last Pap				
Was the last Pap abnormal	Yes	No		
Date of Last Mammogram				
Was the last mammogram abnormal	Yes	No		
Date of Last Colonoscopy				
STD	Yes	No		
PID	Yes	No		
History of Ovarian Cysts	Yes	No		
Urinary Incontinence	Yes	No		
Urinary Frequency	Yes	No		
Burning with Urination	Yes	No		
Urinary Urgency	Yes	No		
Blood in Urine	Yes	No		

OBSTETRIC HISTORY

Total Number of Pregnancies	Full-Term	Pre-Term	Abortion	Ectopic	Multiple	Living

Pharmacy Name: ______________________ Location: _____________________ Phone #: __________________

Primary Care Physician: ________________________ Phone #_______________________________

Specialty Physician: ___________________________ Phone #_______________________________

Patient Signature: ____ Date: ___________________________