## Medical & Wellness History

Have you ever been diagnosed or treated for any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Cancer</td>
<td></td>
<td></td>
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<tr>
<td>High Cholesterol</td>
<td></td>
<td></td>
<td>Blood Clots</td>
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<tr>
<td>Depression/Anxiety</td>
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<td></td>
<td>Kidney Disease</td>
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<tr>
<td>High Blood Pressure</td>
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<td></td>
<td>Liver Disease</td>
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<tr>
<td>Migraine Headaches</td>
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<td></td>
<td>Any operations?</td>
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</tbody>
</table>

Medications being taken: _____________________________________________

List all allergies: ________________________________________________

Do you smoke? □ Yes □ No How much? __________ Do you use drugs? □ Yes □ No What kind? __________

Do you use alcohol? □ Yes □ No How much? __________ How often? __________

Are you satisfied with your current weight? □ Yes □ No

Do you exercise? □ Yes □ No What type? __________ How many times per week? __________

Have you tried to lose weight or control your weight by vomiting, diet pills, or not eating? □ Yes □ No

During the past month: Have you often been bothered by feeling down, depressed, or hopeless? □ Yes □ No

During the past month: Have you often been bothered by little interest or pleasure in doing things? □ Yes □ No

## Family History

Have any of your immediate family members had any of the following? (Please indicate age at diagnosis).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Relationship</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Clot Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease/Attack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Cholesterol</td>
<td></td>
<td></td>
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<tr>
<td>Stroke</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
</tbody>
</table>

## Sexual History

How many sexual partners have you had? __________

Are you currently sexually active? □ Yes □ No

Are you □ Married □ Partnered □ Single □ Divorced?

How long have you been with your current partner? __________

Are your partners: □ men □ women □ both

Age of first vaginal intercourse: __________

Have you felt verbally or physically threatened in your current or past relationships? □ Yes □ No

## Menstrual History

Age of first period: _______ 1<sup>st</sup> day of last period: _______

How often do you have a period? □ 28 days □ 30 days □ other ______

How many days of bleeding each cycle: __________

Days of heavy bleeding: __________

Do you experience severe menstrual cramps? □ Yes □ No

## Annual Exam

Is this your first exam? □ Yes □ No

Any abnormal Paps? □ Yes □ No

If yes, date(s) ______ procedures _______

Date of last Pap ______ result _______

Have you had the HPV vaccine? □ Yes □ No

## Contraception

What is your current method of birth control?

_________________________

Do you want a prescription for a birth control method? □ Yes □ No

If yes, type: __________________________

## Pregnancy History

Have you ever been pregnant? □ Yes □ No □ Unsure

If yes, what was the outcome?

□ # of births ______ □ # of miscarriage ______

□ ectopic pregnancy □ # of abortion ______

Complications of pregnancy? __________________________

Could you currently be pregnant? □ Yes □ No □ Unsure

## Concerns

Any particular concerns or questions we need to discuss today?

_________________________

I have personally reviewed and discussed this form with the patient.

Provider signature: __________________________ Date: __________

6.29.2016

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