allen health clinic

Patient Health History

Personal Information

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Age: _____ Today's Date: _____

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Domestic Partner

Ethnicity: _____ Primary Language: _____

Reason for visit: _____

_____

_____

_____

This form is to help us understand your health history. It will allow us to ensure your records are complete so we can provide the best care possible at the time of your visit. We understand that your answers are very personal, and we will maintain them in the strictest confidence, as is all of your medical information.

Health History

List any medical illnesses: _____

List any medications (Name, Dosage, How often it is taken): _____

List any drug allergies: _____

_____

_____

Tobacco use? _____ *If yes, how much?* _____

Alcohol use? _____ *If yes, how much?* _____

Do you use any illegal drugs? _____ Date of last mammogram: _____

Date of last Dexa Bone Scan: _____ Date of last Colonoscopy: _____

Are you currently pregnant? _____ How many pregnancies have you had? _____

How many living children do you have? _____

Have you had a miscarriage? _____ *If yes, how many?* _____

Have you had an abortion? _____ *If yes, how many?* _____

Have you had a C-Section? _____ *If yes, how many?* _____

List any SURGERIES and YEAR it was performed:

_____

_____

_____

First day of last menstrual period: _____

How often do you have a period? _____

Date of your last pap smear: _____

Have you ever had an abnormal pap smear? _____

If yes, when? _____

Treated with: _____

Have you ever had a sexually transmitted disease? _____

Age of first period: _____

How many days does your period last? _____

Are you currently sexually active? _____

Number of lifetime sexual partners: _____

Method of Birth Control: _____

Have you ever used Gardasil? _____

Have you or your family members had any of the following?

- ❑ Heart Disease
- ❑ High Cholesterol
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Thyroid Problems
- ❑ Hepatitis *(Type: _____)*
- ❑ Tuberculosis
- ❑ Anemia or Blood Disorder
- ❑ AIDS or HIV
- ❑ Birth Defects or Inherited Diseases

Have YOU ever had any of the following?

- ❑ Liver Disease
- ❑ Stomach, Bowel or Gallbladder Problems
- ❑ Asthma
- ❑ Syphilis *(Type: _____)*
- ❑ Herpes or HPV _____
- ❑ Cancer *(Type: _____)*
- ❑ Infertility
- ❑ Rheumatic Fever
- ❑ Allergies
- ❑ Kidney or Bladder Problems
- ❑ Sexual Abuse or Domestic Violence
- ❑ Chlamydia *(Type: _____)*
- ❑ Gonorrhea *(Type: _____)*
- ❑ Breast Problems
- ❑ Sexual Problems