CLEAR FORM

PATIENT HISTORY FORM

YOUR NAME (Last)_____ (First) _____ (M.I.)_____

Date of Birth _____ REFERRED here by _____

Emergency contact _____ Relationship _____ Phone _____

HOW MAY WE CONTACT YOU? Call you at home? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No
Call you at work? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No
Call you on cell? ☐ Yes ☐ No Leave Message? ☐ Yes ☐ No

I attest that the infomation here is true and correct to the best of my belief.

_____ _____
Patient Signature Date

PAST MEDICAL HISTORY

(If you have EVER been diagnosed or treated for any of these conditions, please indicate with an X)

Breast Conditions
_____ Abnormal Mammogram
_____ Breast Cancer ☐ Left ☐ Right
_____ Breast Implants
_____ Fibrocystic Breasts
_____ Other _____

Gyn Problems
_____ Abnormal Pap Smear
_____ Cervical Cancer (Neoplasm)
_____ Dysmenorrhea (Painful Menses)
_____ Endometrial (Uterine) Cancer
_____ Endometriosis
_____ Fibroids
_____ Herpes
_____ Human Papilloma Virus Infection (HPV)
_____ Ovarian Cancer
_____ Ovarian Cysts
_____ Pelvic Inflammatory Disease (PID)
_____ Polycystic Ovarian Syndrome (PCOS)
_____ Sexually Transmitted Disease (STD)
_____ Vaginal Cancer (Neoplasm)
_____ Vulvar Cancer (Neoplasm)
_____ Other _____

Heart or Circulation Conditions (Cardiovascular)
_____ Congenital Heart Disease
_____ Congestive Heart Failure
_____ Coronary Artery Disease
_____ CVA (Stroke)
_____ Hypertension (High Blood Pressure)
_____ Irregular Heart Beat
_____ Mitral Valve Disorders (MVP)
_____ Pulmonary Embolism (Blood Clot in Lung)
_____ Thrombophlebitis (Blood Clot in Extremity)
_____ Other _____

Endocrine (Glandular) Disorders
____ Diabetes – Type I (Insulin-Dependent)
____ Diabetes – Type II
____ Pituitary Gland Disorder
____ Thyroid Disease (Hypo) or (Hyper)
____ High Cholesterol
____ Other _____

____ Immune System Diseases
____ Chronic Fatigue Syndrome
____ Other _____

Gastrointestinal (GI) Problems
____ Colitis, Ulcerative
____ Crohn's Disease
____ Hepatitis A
____ Hepatitis B
____ Hepatitis C
____ Irritable Bowel Syndrome
____ Other _____

Blood (Hematologic) Disorders
____ Anemia
____ Bleeding Disorder
____ Clotting Disorder
____ Sickle Cell Trait or Disease
____ Thalassemia
____ Other _____

Musculoskeletal Disorders
____ Arthritis
____ Arthritis, Rheumatoid
____ Joint Pain
____ Fibromyalgia
____ Osteopenia
____ Osteoporosis
____ Scoliosis
____ Systemic Lupus Erythematosis
____ Other _____

Neurologic Disorders
_____ Common Migraines
_____ Multiple Sclerosis
_____ Seizure Disorder (Epilepsy)
_____ TIA or Stroke
_____ Other _____

Psychiatric or Emotional Conditions
_____ ADHD/ADD
_____ Bipolar (Manic-Depressive)
_____ Major Depression
_____ OCD (Obsessive-Compulsive)
_____ Postpartum Depression
_____ Severe Anxiety or Panic Attacks _____
_____ Other _____
_____

Respiratory (Lung) or ENT Disorders
_____ Asthma
_____ COPD
_____ Lung Cancer
_____ Pneumonia – Recurrent
_____ Sleep Apnea
_____ Tuberculosis
_____ Other _____
_____
_____

Eye Conditions
_____ Glaucoma, if so, what type?
____ Narrow Angle
____ High Pressure
____ Other_____

Urinary (Urological) Disorders
_____ Calculus (Kidney Stones)
_____ Pyelonephritis
_____ Stress Incontinence
_____ Urge Incontinence/Overactive Bladder
_____ Urinary Tract Infections (UTI)
_____ Other _____

Genetic Disorders
_____ Muscular Dystrophy
_____ Other_____

Skin Conditions
_____ Acne (severe)
_____ Eczema
_____ Hirsutism (Excess Hair Growth)
_____ MRSA
_____ Psoriasis
_____ Chicken Pox
_____ Other _____

ALLERGIES

Do you have any known medication allergies? ☐ YES ☐ NO

Allergic to any of the following (select those that apply):

☐ Contrast Dye ☐ Nickel ☐ Peanuts ☐ Latex ☐ Shellfish ☐ Other _____

Please list ALL allergies here and the allergic reaction:

Allergic to	Reaction

IMMUNIZATIONS

Have you had any of the following immunizations? If so, what is the date of the most recent?

Tetanus ☐ Yes ☐ No Date_____
Influenza ☐ Yes ☐ No Date_____
Gardisil ☐ Yes ☐ No Date_____
Other _____

Pneumococcal ☐ Yes ☐ No Date_____
Shingles ☐ Yes ☐ No Date_____
Chicken pox ☐ Yes ☐ No Date_____

PRESCRIPTION MEDICATIONS YOU ARE TAKING

Drug name	Dose	How Often	Start Date	Prescribed by

Primary Pharmacy Name _____ phone # _____

OVER-the-COUNTER VITAMINS, SUPPLEMENTS OR HERBS YOU ARE TAKING

Product name	Dose (if known)	How Often	Start Date	Reason

PAST SURGICAL HISTORY

(Please include any D&C, colposcopy, biopsy of cervix, LEEP, cone biopsy or colonoscopy)

Surgery	Reason	When

Date of last pap test _____ Results _____

Date of last mammogram _____ Results _____

Do you do self breast exams? ☐ Yes ☐ No

Do you have a religious objection to blood transfusions? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

If **ANY** close relative of yours - such as brother, sister, parents, other children, grandparent, aunt or uncle (indicate whether maternal or paternal), - has EVER HAD or CURRENTLY HAS any of the problems listed below, please check the boxes in the YES column and then enter the **specific** relationship to you.

Is your family history known to you? ☐ Yes ☐ No

Endometriosis	☐ Yes	☐ No	Who: _____
Uterine Fibroids	☐ Yes	☐ No	Who: _____
Breast Cancer	☐ Yes	☐ No	Who: _____
Colon Cancer	☐ Yes	☐ No	Who: _____
Heart Disease	☐ Yes	☐ No	Who: _____
High Blood Pressure	☐ Yes	☐ No	Who: _____
High Cholesterol	☐ Yes	☐ No	Who: _____
Blood Clots	☐ Yes	☐ No	Who: _____
Bleeding Disorder	☐ Yes	☐ No	Who: _____
Diabetes – Type I	☐ Yes	☐ No	Who: _____
Diabetes – Type II	☐ Yes	☐ No	Who: _____
Hyperthyroidism	☐ Yes	☐ No	Who: _____
Hypothyroidism	☐ Yes	☐ No	Who: _____
Lung Cancer	☐ Yes	☐ No	Who: _____
Bipolar Disorder	☐ Yes	☐ No	Who: _____
Malignant Tumors (Site)_____	☐ Yes	☐ No	Who: _____
Ovarian Cancer	☐ Yes	☐ No	Who: _____
Uterine Cancer	☐ Yes	☐ No	Who: _____
Other Cancer (What Kind)_____	☐ Yes	☐ No	Who: _____
Osteoporosis	☐ Yes	☐ No	Who: _____

MENSTRUAL HISTORY

Age at first menstrual period _____

IF YOU ARE STILL MENSTRUATING, PLEASE ANSWER THESE QUSTIONS:

First day of your last menstrual period? _____ Are you certain of the date? _____

Cycle interval (28 days or ?) _____ # of days of bleeding with a period _____

How heavy is the flow? ☐ Light ☐ Medium ☐ Heavy

Do you have pain with periods? _____ Break-through bleeding? _____

Pelvic pain of any other nature? _____

Do you use contraception? _____ If so, what type? _____

IF MENOPAUSAL, PLEASE INDICATE STATUS:

☐ PREMENOPAUSAL ☐ POSTMENOPAUSAL ☐ PERIMENOPAUSAL AGE AT MENOPAUSE_____

Your age at last menstrual period? _____ Are you on hormone replacement? _____

Have you had any bleeding since menopause? _____

Are you sexually active? _____ Number of current partners? _____

Did your mother take DES (prescribed to prevent miscarriages from 1938–1971) when she was pregnant with you?_____

Are you currently pregnant? _____

PREGNANCY SUMMARY (Total number)

Total Number of Pregnancies	Full Term Births (> 37 wks)	Premature Births (< 37 wks)	Terminations	Miscarriages- Was Surgery Needed?	Ectopic pregnancies Left or Right?	Multiple births	Stillbirths	Number of Living Children

Please provide dates of terminations, miscarriages and ectopic pregnancies.

Comments: _____

_____

PREGNANCY DETAILS

(Include miscarriages, ectopics and terminations in the sequence):

Child's Birthdate MM/DD/YY	Child's Name	# weeks at Delivery	Length of Labor	Birth Wt.	M or F	Type of Delivery (Vaginal or C/S + C/S type)	Anesthesia	Complications/ Problems	Physician	Location

SOCIAL HISTORY

Occupation: _____ **Education level:** _____

Marital Status: ☐ Married ☐ Engaged ☐ Dating ☐ Not Dating ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Spouse/Partner's name: _____ **Spouse/Partner's occupation:** _____

Caffeine Use: ☐ Yes ☐ No How Much? _____

Tobacco Use: ☐ Never ☐ Current ☐ Former How Much: _____

____ Age started ____ Age stopped

Alcohol Use: ☐ Never ☐ Current ☐ Former How Much: _____

____ Age started ____ Age stopped

"Recreational" Drug Use: ☐ Never ☐ Current ☐ Former Which Drug(s): _____

How Often: _____ ____ Age started ____ Age stopped _____ When last used

Exercise Habits: ☐ Active but no formal exercise ☐ Heavy amount of exercise (4 or more times weekly)

☐ Moderate amount of exercise (1-3 times weekly) ☐ Minimal amount of exercise (Once weekly or less) ☐ Sedentary

Type of exercise: _____

Have you ever been abused? ☐ Yes ☐ No Indicate which: ☐ Emotionally ☐ Physically ☐ Sexually

Were you a: ☐ Child ☐ Teen ☐ Adult when abused?

Are you in an abusive relationship now? ☐ Yes ☐ No

Have you received counseling for this? ☐ Yes ☐ No

Do you have a history of blood transfusion, intravenous drug use, multiple sexual partners or sexual exposure to a gay or bi-sexual male, exposure to an intravenous drug user or have any other reason to believe you may have been exposed to AIDS? ☐ Yes ☐ No

List any sources of chemical or radiation exposure you have encountered: _____

Are you at risk for travel-related illness? ☐ Yes ☐ No Explain: _____

Do you wear your seatbelt? ☐ Yes ☐ No

Military history? ☐ Currently ☐ Previously ☐ Never

Notes: _____

_____