ANNUAL PATIENT HISTORY FORM

Patient Name	Birthdate	Age	Clinic	Patient Number

MEDICAL HISTORY UPDATE

	Yes	No
a. Have you seen a doctor or sought medical care since your last exam?		
b. Any serious illnesses or deaths in your natural family since your last exam?		
c. Do you smoke? If yes, amount/day:		
d. Do you use drugs? If yes, amount/week:		
e. Do you drink alcohol? If yes, amount/week:		
f. Depression/mood swings in the past year?		
ARE YOU HAVING OR HAVE YOU HAD ANY OF THE FOLLOWING (If yes, circle type)	Yes	No
g. Abdominal pain/nausea		
h. Chest pain/shortness of breath		
i. Severe headaches/changes-in-vision		
j. Pain/tingling/swelling (hands, legs, feet)		
K. Do you have any concerns about abuse/force (sexual, physical, or emotional)		
l. Urinary problems		

MEDICATION HISTORY: List all medications you are taking now (include prescription drugs, vitamins, and herbal medication):

List Medication and/or Latex Allergies: ☐ None Known

PREGNANCY HISTORY

	Yes	No
a. Number of times pregnant ________ Number of living children ________		
b. Could you be pregnant now?		
c. Are you planning to become pregnant in the next 2 years?		

. COMPLETE THE FOLLOWING TABLE FOR EACH PREGNANCY SINCE YOUR LAST EXAM

Date Pregnancy Ended	Problems with Pregnancy	Wt. of Baby	No. Weeks Pregnant	Type of Delivery
1.				
2.				

GYNECOLOGICAL HISTORY

a. First day of last or current period ______ / ______ / ______

ARE YOU HAVING OR HAVE YOU HAD ANY OF THE FOLLOWING (If yes, circle problem)

b. Do you examine your own breasts? ☐ Yes ☐ No

c. Cramps? ☐ Yes ☐ No

d. Bleeding/spotting between periods? ☐ Yes ☐ No

e. Pain/Bleeding during intercourse? ☐ Yes ☐ No

f. STD? (chlamydia, gonorrhea, herpes, warts, HIV/AIDS) ☐ Yes ☐ No

g. Unusual vaginal discharge/odor/genital sores? ☐ Yes ☐ No

h. Does your partner use condoms? ☐ Yes ☐ No

i. How many sex partners have you had in the last year? ______________

Partners are: __________ Male __________ Female __________ Both

j. Type of sexual contact ☐ Vaginal ☐ Mouth ☐ Anal

k. Is there anything that runs in your family or your partners family that concerns you about having children? ☐ Yes ☐ No

If yes, would you like genetic information? ☐ Yes ☐ No

Referred to ______________________________

l. Current Birth Control Method: ______________________________

Any problems with it? ☐ Yes ☐ No

m. Please respond:	OK	NOT OK	NEVER
Date of last Mammogram _____ / _____ / _____	☐	☐	☐
Date and result of last Pelvic _____ / _____ / _____	☐	☐	☐
Date and result of last Pap Tests _____ / _____ / _____	☐	☐	☐

All Information Is Confidential

Patient's Signature: ______________________________

Date: ______ / ______ / ______

STAFF NOTES

Signature/Title Date

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