Confidential Health History

Seven Oaks Women's Center

7711 Louis Pasteur, Suite 200
San Antonio, Texas 78229

Updated 08/07

Name:	Age:	Birth Date:
Physician's Name:	Patient's ID Number:	
Referring Physician / Person:	Today's Date:	
Please describe any special problems or symptoms that you would like to discuss.		

PREVENTIVE HEALTH

	Date of last:		Date of last:		Date of last:
Bone Density		Pelvic Ultrasound		Colonoscopy	
Pap		Mammogram		Cholesterol	
HPV		Cystic Fibrosis		Cystoscopy	
Was last pap: ☐ Normal ☐ Abnormal		If abnormal how treated:		Breast Cancer Gene	

PAST MEDICAL HISTORY

Have you ever had any problems related to:					
Heart / Blood Pressure	☐ Yes	☐ No	Emotional / Mental Illness	☐ Yes	☐ No
Kidney's / Bladder	☐ Yes	☐ No	Endocrine Hormones / Thyroid / Diabetes	☐ Yes	☐ No
Lungs	☐ Yes	☐ No	Neurologic System / Seizures	☐ Yes	☐ No
Blood (anemia, clots, etc.)	☐ Yes	☐ No	Sexually Transmitted Diseases	☐ Yes	☐ No
Digestive System (colon)	☐ Yes	☐ No	Other Medical Illness	☐ Yes	☐ No

SURGERIES and MAJOR INJURIES

Date	Hospital	Surgery Type

CURRENT MEDICATION

Medication	Frequency of Dose	Medication	Frequency of Dose

LATEX ALLERGIES

Are you allergic to latex? ☐ Yes ☐ No	What type of reaction do you have?	Does reaction interfere with any activities? ☐ Yes ☐ No

MEDICATION ALLERGIES

Do you have any medication allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?	Does reaction interfere with any activities? ☐ Yes ☐ No

FOOD ALLERGIES

Do you have any food allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?	Does reaction interfere with any activities? ☐ Yes ☐ No

ENVIRONMENTAL ALLERGIES

Do you have any environmental allergies? ☐ Yes ☐ No	If yes, to what?	What type of reaction do you have?	Does reaction interfere with any activities? ☐ Yes ☐ No

MENSTRUAL HISTORY

Age period began:	First day of last normal menstrual period - Date:	Length of periods (# of days of bleeding):	Number of days between periods:	Heaviest day of your menstrual flow, how many full-sized pads or tampons would you soak?

Do you take any medications for your periods? ☐ Yes ☐ No	Any recent changes in periods? ☐ Yes ☐ No	Do you ever have bleeding in between your periods? ☐ Yes ☐ No	Do you ever have bleeding with intercourse? ☐ Yes ☐ No

Physician's Name:	Patient's ID Number:

SEXUAL HISTORY

Present method of birth control:	Have you ever used an intrauterine device (IUD)? ☐ Yes ☐ No	Have you ever used birth control pills? ☐ Yes ☐ No	If yes for how long?
Have you ever had sex? ☐ Yes ☐ No	Are you currently sexually active? ☐ Yes ☐ No	Number of sexual partners (year):	Sexual partners are: ☐ Men ☐ Women ☐ Both
Any sex partners use IV drugs, bi-sexual or hemophiliacs? ☐ Yes ☐ No	Do you have pain with intercourse? ☐ Yes ☐ No	Have you ever had vaginal infections? ☐ Yes ☐ No	Have you ever had pelvic infections (PID)? ☐ Yes ☐ No
Have you ever had any sexually transmitted diseases? ☐ Yes ☐ No	If so, what type of STD?	Do you desire contraceptive information? ☐ Yes ☐ No	Are you a D.E.S. daughter? ☐ Yes ☐ No

Are there any other issues related to sexual activity which you would like to discuss?

REPRODUCTIVE HISTORY

# of times pregnant:	# of deliveries prior to 37 weeks:	# of living children:
# of term deliveries:	# of losses prior to 20 weeks or abortion:	weight of largest baby:
# of c-sections: reason:		weight of smallest baby:

Has there been a time when you have been having intercourse, have not used contraception, yet have not become pregnant? ☐ Yes ☐ No	If desiring pregnancy how old is your partner?	Has he ever fathered any children? ☐ Yes ☐ No
Does he have any health problems? ☐ Yes ☐ No	If yes, what type?	

Have you ever had any of the following pregnancy complications:

High blood pressure ☐ Yes ☐ No	Diabetes ☐ Yes ☐ No	Premature labor ☐ Yes ☐ No	Other
Kidney infections ☐ Yes ☐ No	Bleeding ☐ Yes ☐ No	Birth defects ☐ Yes ☐ No	

If you are pregnant now, have you been exposed to:

Medications ☐ Yes ☐ No	Drugs ☐ Yes ☐ No	X-rays ☐ Yes ☐ No	Other
Smoking ☐ Yes ☐ No	Alcohol ☐ Yes ☐ No	Cats ☐ Yes ☐ No	

If you are pregnant now, have you had a rash or viral illness during your pregnancy? ☐ Yes ☐ No	Are your family and the father of the fetus' family related in any way? ☐ Yes ☐ No

URINARY HISTORY

Have you had bladder infections? ☐ Yes ☐ No	Have you had kidney infections? ☐ Yes ☐ No	Do you have burning on urination? ☐ Yes ☐ No	Do you have blood in your urine? ☐ Yes ☐ No
Do you lose urine on coughing, sneezing, laughing, running? ☐ Yes ☐ No	If so does this require daily pad use? ☐ Yes ☐ No	Do you urinate frequently? ☐ Yes ☐ No	Do you get up at night to urinate? ☐ Yes ☐ No
Do you have an uncomfortable bulge in your vagina? ☐ Yes ☐ No	Do you leak urine with intercourse? ☐ Yes ☐ No	Do you have an urgency to urinate such that you will lose urine if a bathroom is not available? ☐ Yes ☐ No	

MENOPAUSAL SYMPTOMS

Are you bothered by hot flashes? ☐ Yes ☐ No	Are you bothered by vaginal dryness? ☐ Yes ☐ No	Are you bothered by difficulty sleeping? ☐ Yes ☐ No	Other problems that you feel could be related? ☐ Yes ☐ No

FAMILY HISTORY Have any of your close relatives had any of the following conditions?

Condition:	Relation to you	Relation to spouse	Condition:	Relation to you	Relation to spouse
Anemia related to Mediterranean or black ethnicity			High blood pressure		
Chromosomal abnormalities (I.e. Down's Syn.)			Huntington's Chorea		
Neural tube defect (I.e., spina bifida or anencephaly)			Mental retardation		
Birth defects/Genetic disorder			Muscular dystrophy		
Bleeding disorder or blood clot formation			Osteoporosis		
Breast cancer			Ovarian cancer		
Colon cancer			Sickle Cell Disease or trait		
Cystic fibrosis			Tay-Sachs Disease		
Diabetes			Three or more miscarriages		

Physician's Name:	Patient's ID Number:

ANCESTRY Please indicate if you or your spouse are of the following ancestry.

Ancestry:	You	Spouse		You	Spouse
Ashkenazi Jewish	☐ Yes ☐ No	☐ Yes ☐ No	Have you been tested for Tay-Sachs?	☐ Yes ☐ No	☐ Yes ☐ No
Black	☐ Yes ☐ No	☐ Yes ☐ No	Have you been tested for Sickle cell trait?	☐ Yes ☐ No	☐ Yes ☐ No
Mediterranean (Italian, Greek)	☐ Yes ☐ No	☐ Yes ☐ No	Have you been told that you had an anemia or been tested for thalassemia?	☐ Yes ☐ No	☐ Yes ☐ No
Southeast Asian, Philippines	☐ Yes ☐ No	☐ Yes ☐ No			

SOCIAL HISTORY

Marital Status (circle one) Single Married Widowed Divorced Partnered Engaged Separated	Number of children living at home:
Patient Employer:	Husband / Patient's Employer

Name and age of children:		
Do you / did you ever drink alcohol? ☐ Yes ☐ No	What type?	For how many years?
	How much per week?	When did you stop?
Do you / did you ever use tobacco? ☐ Yes ☐ No	What type?	For how many years?
	How much per day?	When did you stop?
Do you / did you ever abuse any other recreational or prescription drugs? ☐ Yes ☐ No	What type?	When did you start?
	How much per day?	When did you stop?
Do you exercise? ☐ Yes ☐ No	How often?	

In the last two (2) years have you used any of the following?

Speed / Uppers ☐ Yes ☐ No	Marijuana ☐ Yes ☐ No	Cocaine ☐ Yes ☐ No	PCP "Angel Dust" ☐ Yes ☐ No
Quaaludes / Downer ☐ Yes ☐ No	Heroin ☐ Yes ☐ No	Crack ☐ Yes ☐ No	Diet Pills ☐ Yes ☐ No
Tranquilizers that were not prescribed by a doctor ☐ Yes ☐ No		Other	

REVIEW OF SYSTEMS Check (✓) symptoms you currently have or have had in the past.

CONSTITUTIONAL	RESPIRATORY	MUSCULOSKELETAL
☐ Fatigue	☐ Cough	☐ Difficulty walking up stairs
☐ Fever	☐ Coughing up phlegm	☐ Muscle or joint pain
☐ Weight gain unexplained in past 3 months	☐ Difficulty breathing	SKIN
☐ Weight loss in past 3 months	☐ Spitting up blood	☐ Rash
EYES	GASTROINTESTINAL	ENDOCRINE
☐ Blurred or double vision	☐ Abdominal bloating	☐ Heat or cold intolerance
EARS, NOSE, THROAT	☐ Abdominal pain	☐ Night sweats
☐ Difficulty smelling	☐ Blood in stool	☐ Breast discharge
☐ Ear pain or hearing loss	☐ Constipation	NEUROLOGIC
☐ Nasal congestion	☐ Diarrhea	☐ Dizzy spells
CARDIOVASCULAR	☐ Indigestion	☐ Frequent headaches
☐ Swelling of feet or ankles	☐ Vomiting	☐ Numbness in fingers
☐ Irregular heart beat	☐ Difficulty passing stool	☐ Weakness
☐ Murmur	HEMATOLOGIC/LYMPHATIC	PSYCHIATRIC
☐ Pain in chest	☐ Easy bruising	☐ Crying spells
	☐ Enlarged lymph nodes	☐ Insomnia
	☐ Easy bleeding	☐ Work or family problems
	☐ Bleeding does not stop easily	☐ Depression
		☐ Anxiety

VERIFICATION

Form Completed By: ☐ Patient ☐ Medical Assistant ☐ Physician _____ ☐ Office Nurse (name or initials)	Patient Signature:
Date Reviewed By Physician With Patient:	Physician Signature:

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