For Updates – Please initial/date changes and sign/date the back page

MOSCOW-PULLMAN OB/GYN
ANNUAL HEALTH HISTORY

TODAY'S DATE _____

In order to assist your Doctor in providing you with the best medical care, please take some time to fill out this history. All information is held strictly confidential and can only be released with your written permission.

NAME _____ **DATE OF BIRTH** _____

ALLERGIES _____

CURRENT MEDICATIONS

Medication	**Dosage (milligrams, mcg, etc.)**	**How many do you take per day?**

MEDICAL HISTORY *(circle yes or no)**:***
Do you have or have you ever had:

High blood pressure	Yes	No	Epilepsy - Seizures	Yes	No
Heart Disease	Yes	No	Psychiatric illness	Yes	No
Heart Murmur	Yes	No	Depression	Yes	No
Lung Disease	Yes	No	Thyroid problems	Yes	No
Tuberculosis	Yes	No	Excessive Hair Growth	Yes	No
Asthma	Yes	No	Unexplained Abdominal Pain	Yes	No
Blood Clots	Yes	No	Diabetes/Gestational Diabetes	Yes	No
Free bleeding - hemophilia	Yes	No	Hernia	Yes	No
Blood transfusions	Yes	No	Kidney Disease	Yes	No
Hepatitis - Jaundice	Yes	No	Rubella	Yes	No
Cancer	Yes	No	Colonoscopy	Yes	No
MRSA	Yes	No	Other _____	Yes	No

GYNECOLOGICAL HISTORY *(fill in information and/or circle yes or no)**:***

When was your last Pap smear? Date: _____
When was your last mammogram? Date: _____
How often do you examine your breasts? _____
Age at onset of first menstrual period? _____

Are your cycles irregular?	Yes	No	Interval: _____
Is your flow abnormal?	Yes	No	Duration: _____
Are your cycles painful?	Yes	No	*(circle one):* Mild Moderate Severe
Do you have abnormal bleeding?	Yes	No	Describe: _____
Have you had an abnormal Pap?	Yes	No	List date & treatment: _____
Have you been exposed to DES?	Yes	No	Not sure
(Your mother may have taken DES to prevent miscarriage in the mid 1940's to mid 1970's.)			
Have you ever had a breast problem?	Yes	No	
Are you using contraception?	Yes	No	List type & any complications: _____
Are you sexually active?	Yes	No	More than one partner? _____
Do you have pain with intercourse?	Yes	No	Describe: _____
Do you have an abnormal discharge?	Yes	No	List any symptoms: _____
Have you ever had a STD?	Yes	No	*(circle)* Chlamydia GC Trich Herpes HIV Hepatitis B HPV
Have you ever had a pelvic infection?	Yes	No	*(circle)* Appendicitis PID Abscess
Do you have problems with bowels?	Yes	No	*(circle)* Constipation Diarrhea Pain Blood
Have you gone through menopause?	Yes	No	If yes, dates: _____
Have you taken hormone replacement?	Yes	No	*(circle)* Estrogen Progesterone Natural
Do you have problems urinating?	Yes	No	*(circle)* Burning Frequent Urgent Leaking During night

PLEASE TURN OVER AND COMPLETE THE BACK PAGE

INFERTILITY

Have you had problems getting pregnant? Yes No Infertility treatments: _____

OBSTETRICAL HISTORY

Please list any pregnancies you have had, including miscarriages, ectopic pregnancies, and abortions.

Date	**Gestational Age**	**Birth Weight**	**Baby's Name**	**Complications**

PREVIOUS HOSPITALIZATIONS/SURGERIES including Date occurred*:*

_____

_____

_____

_____

_____

PERSONAL HABITS *(circle yes or no)**:***

Drink alcohol?	Yes	No	If yes, number of drinks per week: _____
Smoke?	Yes	No	If yes, for how long: _____, list number of packs per day _____
Used drugs?	Yes	No	If yes, list type & date last used: _____
Had an eating disorder?	Yes	No	
Had problems sleeping?	Yes	No	
Exercise?	Yes	No	If yes, list type & frequency: _____
Caffeine?	Yes	No	If yes, number of cups per day: _____

FAMILY HISTORY *(circle yes or no)**:***

Alcoholism:	Yes	No	If yes, who? _____
Bleeding Disorder	Yes	No	If yes, who? _____
Cancer	Yes	No	If yes, who? _____
Diabetes	Yes	No	If yes, who? _____
Heart Disease	Yes	No	If yes, who? _____
High Blood Pressure	Yes	No	If yes, who? _____
Kidney Disease	Yes	No	If yes, who? _____
Mental Illness	Yes	No	If yes, who? _____
Osteoporosis	Yes	No	If yes, who? _____
Stroke	Yes	No	If yes, who? _____
Cystic Fibrosis	Yes	No	If yes, who? _____
Other _____	Yes	No	If yes, who? _____

PHYSICIAN'S SIGNATURE	**DATE**	**PATIENT'S SIGNATURE**	**DATE**
_____		_____	
_____		_____	
_____		_____	
_____		_____	