Health History Form *Karen Goodrich, M.D.*

Patient's Name:_____
Date:_____
Date of Birth:_____ Age:_____
Occupation: _____ Employer: _____
Status: Single Partnered Married Separated Divorced Widowed
Reason for visit: _____

GYNECOLOGIC HISTORY:
Menstrual history: Age during first period:____ First day of last period:_____
Frequency of periods:_____ days Length of periods:_____ days
# of pads/tampons used on heaviest days:_____
Pap smears: Date of last pap smear:_____ Results:_____
Birth Control:_____ Hormone therapy:_____
Breasts: Date of last mammogram: _____ Results: _____
Have you ever experienced any of the following: If yes, please explain

Painful periods:	No Yes:	_____
Irregular cycles:	No Yes:	_____
Bleeding between periods:	No Yes:	_____
Bleeding after intercourse:	No Yes:	_____
Large clots with periods:	No Yes:	_____
Abnormal Pap Smears:	No Yes:	_____
Breast Aspiration Biopsy:	No Yes:	_____
Infertility Treatment:	No Yes:	_____
Sexually Transmitted Infection:	No Yes:	_____
(Herpes, Warts, Chlamydia, Gonorrhea, Pelvic infection)		
Do you want to be tested for any sexually transmitted infections?:		_____
New sexual partners since last exam	No Yes:	_____
Pain or problems with intercourse:	No Yes:	_____
Problems with loss of urine:	No Yes:	_____
Endometriosis:	No Yes:	_____
Fibroids:	No Yes:	_____
Ovarian Cysts:	No Yes:	_____

OBSTETRICAL HISTORY: Dates and outcomes of all pregnancies (miscarriage, abortion, ectopic, preterm and term pregnancies): _____
_____
_____
_____
_____

Patient's signature:_____ Reviewed by M.D. _____

MEDICAL HISTORY:

Have you ever had any of the following?:

Heart Disease:	Heart Murmur	No Yes
	High Blood Pressure	No Yes
	Heart Attack	No Yes
	Chest Pain	No Yes
	Palpitations/Irregular Heart Beat	No Yes
Lung Disease:	Shortness of Breath	No Yes
	Asthma	No Yes
	Emphysema	No Yes
Liver Disease:	Hepatitis or Jaundice	No Yes
Kidney Disease:	Urinary Tract Infection	No Yes
	Kidney Infection	No Yes
	Kidney Stones	No Yes
Gastrointestinal Problems:		
	Chronic Constipation/Diarrhea	No Yes
	Ulcers	No Yes
	Bloody Stools	No Yes
Nervous System/Psychological Problems:		
	Strokes	No Yes
	Seizures/Epilepsy	No Yes
	Headaches/Migraines	No Yes
	Fainting	No Yes
	Nerve Paralysis	No Yes
	Depression	No Yes
	Eating Disorders	No Yes
Blood Disorders:	Bleeding Disorders	No Yes
	Blood Clots in Legs or Lungs	No Yes
	Varicose veins	No Yes
	Easy Bruising	No Yes
	Anemia	No Yes
	Sickle Cell Anemia	No Yes
Metabolic Disease:	Diabetes	No Yes
	Thyroid Disease	No Yes
	High Cholesterol	No Yes
Muscle and Bone Disease:		
	Constant Back Pain	No Yes
	Osteoporosis	No Yes
Skin Disease:	Skin Cancer	No Yes
	Melanoma	No Yes
	Abnormal Moles	No Yes
Autoimmune Disease:		
	Lupus	No Yes

SURGICAL HISTORY: Dates and details of all operations/hospitalizations:_____

_____

_____

_____

Patient's Signature: _____ Reviewed by M.D._____

MEDICATIONS: List all medications and supplements including dosages.
Medication: Dosage:

_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES: List all allergies and reactions to medications.
Medication: Reaction:

_____
_____
_____
_____

FAMILY HISTORY: List family members with any of the following problems and describe.

Breast Cancer: _____
Ovarian Cancer: _____
Colon Cancer: _____
Other types of cancer: _____
High Blood Pressure: _____
Heart Disease or Heart Attack: _____
Diabetes: _____
Stroke: _____
Blood Clot in Lungs or Legs: _____
Bleeding Tendency: _____
Other: _____

SOCIAL HISTORY:

Do you drink alcohol? _____ How much? _____
Do you smoke? _____ How much? _____
Do you use recreational drugs? _____
Any problems with alcohol or drugs? _____
Do you feel safe at home? _____
Any history of abusive relationship? _____
Do you exercise regularly?_____
Do you wish to discuss any risk related behaviors? _____
Is stress a problem for you currently? _____
Have you ever felt depressed? _____
Have you ever felt suicidal or attempted suicide? _____
Have you ever been to a counselor? _____
Do you wish to discuss any other issues? _____

Patient's Signature _____ Reviewed by M.D._____