PATIENT LABEL

SWEDISH COVENANT MEDICAL ASSOCIATES
Personal Health History Form
NMS

DATE: _____ **REFERRED BY:** _____

PRIMARY DOCTOR: _____ **PREFERRED LANGUAGE:** _____

ALLERGIES None ☐

_____

REASON FOR TODAY'S VISIT

_____

_____

PERSONAL INFORMATION

Age: _____ **Birth Date:** _____ **Marital Status:** Married Single Divorced Widowed

Current or most recent occupation: _____

GYNECOLOGICAL HISTORY

First day of your last Menstrual Period: ____/____/____

Date of your last Pap Test: ____/____/____ Results : Normal Abnormal (Please circle one)

If abnormal, explain: _____

Have you ever had an abnormal Pap Test? Yes No If yes, explain: _____

Age of your first period: _____

Length of your period: _____(Number of bleeding days) Number of days between each period: _____

Have you had any menstrual problems? Yes No If yes, explain: _____

Are you in a sexual relationship? Yes No

Are there any sexual problems? Yes No If yes, explain: _____

Sexual Partners are: Men Women Both Total number of sexual partners in your lifetime: _____

Method of birth control: Presently _____ In the Past _____

Date of Last Mammogram: ____/____/____ Date of Last Bone Scan : ____/____/____

Any Breast Biopsies: Yes No If yes, dates: _____

PAST PREGNANCIES:

DATE MONTH/ YEAR	# GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE OF DELIVERY: VAGINAL or C-SECTION	EPIDURAL YES / NO	PLACE OF BIRTH	PRETERM LABOR YES / NO	MISCARRIAGE ABORTION ECTOPIC TUBAL (PLEASE SPECIFY)	PRENANTAL COMMENTS /COMPLICATIONS: I.e. Hypertension / Diabetes / Hemorrhage post partum

Medications:	None ☐		
Name	**Dosage**	**Name**	**Dosage**

MEDICAL HISTORY:ILLNESS	NO	YES		NO	YES
Diabetes			Heart Disease		
High Blood Pressure			Stroke		
Sexually Transmitted Diseases			Headaches/Migraines		
Osteoporosis/Bone Disease			Seizures		
Thyroid Disease			Asthma/Lung Disease		
Urinary Tract Infections			Kidney Infections/Stones		
Blood Clots in Lungs or Legs			Ulcers/Reflux		
Depression/Anxiety			Bowel Problems		
Cancer			Hepatitis/Liver Disease		
Anemia			Gall Bladder Disease		

SURGERIES	☐ None	
DATE	SURGERY	ANY COMPLICATIONS

SOCIAL HISTORY		YES	NO		
Tobacco	☐ Past			*Packs per day:*	*Years:*
	☐ Present			*Packs per day:*	
Alcohol	☐ Past			*Drinks per week:*	*Years:*
	☐ Present			*Drinks per week:*	
Drugs	☐ Past			*Type of Drug:*	*How used:*
	☐ Present			*Type of Drug:*	*How used:*
Have you ever been sexually, physically or verbally abused?				By Whom?	Currently?
Supplements / Herbals				Quantity:	Dose:
Health Hazards at Home/Work					
Seat Belt Use					
Folic Acid Intake					
Calcium Intake					
Caffeine Intake					
Other					
Diet (check any that apply): ☐Vegan ☐Vegetarian ☐ Lactose Intolerant ☐Other explain:					
Regular Exercise: Type				How Often:	

FAMILY HISTORY (FH):							
Mother: ☐ Living ☐ Deceased Cause: Age:				Father: ☐ Living ☐ Deceased Cause: Age:			
Siblings: Number Living: Number Deceased: Cause:							
FAMILY HISTORY	**Yes**	**No**	**Relationship**		**Yes**	**No**	**Relationship**
Breast Cancer				Stroke			
Colon Cancer				Heart Disease			
Ovarian Cancer				High Blood Pressure			
Uterine Cancer				High Cholesterol			
Cancer Other				Birth defects or Mental Retardation			
Blood Clots in Legs or				Alcoholism or Drug Abuse			
Osteoporosis				Alzheimer's Disease			
Diabetes				Other			

REMAINDER TO BE COMPLETED BY PROVIDER

☐ New Patient ☐ Established Patient ☐ Consultation

Primary Care Physician:	Who Sent Patient:
Other Physician(s):	
Last Colorectal Screening Date: / /	

Review of System (ROS) :	
1. Constitutional	☐ Weight Loss ☐ Weight Gain ☐ Fatigue
2. Eyes	☐ Vision Change
3. Cardiovascular	☐ Chest Pain ☐ Palpitations or Irregular Heartbeat
4. Respiratory	☐ Shortness of Breath ☐ Cough
5. Gastrointestinal	☐ Bloody Stool ☐ Involuntary loss of gas or stool ☐ Vomiting ☐ Diarrhea ☐ Constipation
6. Urinary	☐ Frequency of urination ☐ Bloody Urine ☐ Painful Urination ☐ Urgency to Urinate ☐ Incomplete Emptying ☐ Involuntary Loss of urine
7. Pelvic	☐Painful Intercourse ☐Pelvic pain ☐Pelvic Pressure ☐PMS ☐Abnormal/Painful Periods
8. Breast	☐ Nipple Discharge ☐ Breast Lump ☐ Breast Tenderness
9. Psychiatric	☐ Anxiety ☐ Depression
10. Endocrine	☐ Hot Flashes ☐ Abnormal thirst ☐ Hair Loss ☐ Heat/Cold Intolerance ☐ Dry Skin

PATIENT SIGNATURE: _____ DATE_____

PATIENT COUNSELED: _____ DATE_____

PHYSICIAN SIGNATURE: _____ DATE_____