Health History – The Midwives Clinic at NW

Name: Last _____ **First** _____ **MI** _____ **Date:** _____

Birthdate: _____ **Gender:** _____ **E-Mail:** _____

REASON FOR VISIT: _____ **Preferred Pharmacy:** _____

Allergies: ☐ No Allergies	**Medication or Substance**	**Reaction**

Current Medications:	**Label - Name**	**Dose**	**Frequency**
OR			
☐ See Attached List			

Social History

☐ Single ☐ Married ☐ Domestic Partner (Spouse/Partner Name: _____) # Kids _____

Do you use tobacco products? ☐ Daily ☐ Some Days ☐ Quit ☐ Passive (around cigarette smoke) ☐ Never
Packs per Day _____ Years Smoked _____ Date Quit _____
Type(s) of Tobacco: ☐ Cigarettes ☐ Cigars ☐ E-Cigarettes ☐ Chew ☐ Snuff

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit Date Quit _____
Drinks per Day _____ Drinks per Week _____ Type: ☐ Beer ☐ Wine ☐ Liquor

Do you use recreational drugs? ☐ Never ☐ Yes – Use per Week _____ ☐ No ☐ Quit Date Quit _____
Have you ever used intravenous (IV) drugs: ☐ Yes ☐ No
Types: ☐ Cocaine ☐ Marijuana ☐ Methamphetamines ☐ Stimulants ☐ Heroin
☐ Depressants ☐Hallucinogens (LSD, mushrooms) ☐ Opioids (vicodin, oxycodone)

Are you sexually active? ☐ Yes ☐ No Partners: ☐ Male ☐ Female Birth Control: _____

Are you working? ☐ Yes What do you do? _____ ☐ No ☐ Retired ☐ Disabled

Women's Health

	Yes	No	
Have you ever been pregnant?	☐	☐	# pregnancies: _____ # deliveries: _____ # full term births: _____
Are you currently pregnant?	☐	☐	# of Weeks: _____
			Any problems with pregnancy? _____
Menstrual Period	☐	☐	First day of last period: _____ Period occurs every: _____ days.
			Age of first period: _____
			Cramps: ☐ Mild ☐ Moderate ☐ Severe
			Flow: ☐ Light ☐ Moderate ☐ Heavy
			Spotting between periods? ☐ Yes ☐ No
Menopause	☐	☐	Age: _____
			If Menopausal, have you ever used a hormone replacement?
			☐ Yes ☐ No If yes, what was used _____

PLACE PATIENT LABEL HERE

Health Maintenance

	Yes	No		
Pap Smear	☐	☐	Date:	_____
Mammogram	☐	☐	Date:	_____
Colonoscopy	☐	☐	Date:	_____
Last STD Test	☐	☐	Date:	_____

Medical History

Please check box for those conditions you have now or have ever had.

- ☐ No Past Medical History
- ☐ Abnormal Pap
- ☐ Abnormal Uterine Bleeding
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ CHF
- ☐ Clotting Disorder
- ☐ COPD
- ☐ Coronary Atherosclerosis
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ GERD
- ☐ Headaches
- ☐ Hepatitis
- ☐ HIV
- ☐ Hypertension
- ☐ Infertility
- ☐ Kidney Disease
- ☐ Lipid/Cholesterol
- ☐ Migraine
- ☐ Osteoporosis
- ☐ Pelvic Pain
- ☐ PID
- ☐ Pulmonary Embolism
- ☐ Rash or Skin Problem
- ☐ Seizures
- ☐ Sexually Transmitted Infection
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Disease
- ☐ Urinary Incontinence
- ☐ Urinary Tract Infection
- ☐ Other (Please list): _____

Surgical History

Please check box for any surgery you have had. Indicate the year (YYYY).

- ☐ No Past Surgical History
- ☐ Abdomen Surgery (____)
- ☐ Appendectomy (____)
- ☐ Bladder Suspension (____)
- ☐ Breast Surgery (____)
- ☐ C-SECTION (____)
- ☐ Cervical Conization (____)
- ☐ Cervical Dysplasia Treatment (____)
- ☐ Colon Surgery (____)
- ☐ Colporrhaphy (____)
- ☐ Colposcopy (____)
- ☐ Cosmetic Surgery (____)
- ☐ D&C (____)
- ☐ Endometrial Ablation (____)
- ☐ Essure Sterilization (____)
- ☐ Gall Bladder Removal (____)
- ☐ Hernia Repair (____)
- ☐ Hysterectomy (____)
- ☐ Hysteroscopy (____)
- ☐ Induced Abortion (____)
- ☐ LEEP (____)
- ☐ Mastectomy (____)
- ☐ Myomectomy (____)
- ☐ Ovary Removal (____)
- ☐ Pelvic Laparoscopy (____)
- ☐ Tonsillectomy (____)
- ☐ Tubal Ligation (____)
- ☐ Other (Please list): _____

Family History – Check all that apply

Relationship	First Name	Status (circle)	No Family History	Birth Defects	Blood Clots	Breast Cancer	Colon Cancer	Ovarian Cancer	Prostate Cancer	Diabetes	Endometriosis	Fibroids	Heart Disease	Hyperlipidemia	Hypertension	Thyroid Disease	Osteoporosis	Other:
Mother		alive deceased																
Father		alive deceased																
Maternal Grandmother		alive deceased																
Brother		alive deceased																
Sister		alive deceased																
Maternal Grandfather		alive deceased																
Paternal Grandmother		alive deceased																
Paternal Grandfather		alive deceased																
Other:		alive deceased																

PLACE PATIENT LABEL HERE

Screening

In the past two weeks, how often have you been bothered by the following? (Please circle one response per statement.)

Little interest or pleasure in doing things	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless	Not at all	Several days	More than half the days	Nearly every day

Have you fallen in the past year? ☐ Yes ☐ No
Are you afraid of falling? ☐ Yes ☐ No
Do you have issues with balance or feeling unsteady? ☐ Yes ☐ No
Do you feel safe at home? ☐ Yes ☐ No

Immunizations

	Yes	No				
HPV	☐	☐	When:	_____	Where:	_____
Flu	☐	☐	When:	_____	Where:	_____
Pneumonia	☐	☐	When:	_____	Where:	_____
TDAP	☐	☐	When:	_____	Where:	_____
Tetanus	☐	☐	When:	_____	Where:	_____

Review of Systems (Current Symptoms) – Please check only if these are bothering you at this time

Gastrointestinal:
- ☐ Poor Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn/Indigestion
- ☐ Stomach Pain
- ☐ Constipation
- ☐ Vomiting Blood
- ☐ Black Tarry Stools
- ☐ Diarrhea
- ☐ Abdominal Swelling
- ☐ Trouble Swallowing
- ☐ Rectal Bleeding
- ☐ Other (Please list):

Constitutional:
- ☐ Fevers
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Night Sweats/ Hot Flashes

Head/ Eyes:
- ☐ Cataracts
- ☐ Dry Eyes
- ☐ Poor Vision
- ☐ Color Blindness

Ears/ Nose/ Mouth/ Throat:
- ☐ Hearing Loss
- ☐ Chronic Sinus Congestion
- ☐ Heavy Snoring
- ☐ Bad Teeth

Respiratory (Lungs):
- ☐ Cough
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Emphysema (COPD)

Heart:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Irregular Heart Beat
- ☐ High Blood Pressure

Genitourinary:
- ☐ Sexual Problems
- ☐ Burning with Urination
- ☐ Blood in Urine
- ☐ Leakage of Urine
- ☐ Vaginal Discharge
- ☐ Pelvic Pain

Muscle/ Bones:
- ☐ Chronic Pain
- ☐ Arthritis
- ☐ Muscle Weakness
- ☐ Muscle Cramping
- ☐ Bone Pain
- ☐ Joint Pain

Skin:
- ☐ Rash
- ☐ Jaundice
- ☐ Itching
- ☐ Psoriasis

Neurological:
- ☐ Headaches
- ☐ Seizures (Epilepsy)
- ☐ Confusion
- ☐ Tremor (Shaking)

Vascular:
- ☐ Blood Clots
- ☐ Varicose Veins

Psychosocial:
- ☐ Anxiety / Nerves
- ☐ Abusive Relationship
- ☐ Sexual Problems
- ☐ Sleep Problems
- ☐ Alcohol Use
- ☐ Depression
- ☐ Feeling Worthless
- ☐ Want to Hurt Yourself
- ☐ Want to Hurt Others
- ☐ Drug Use

Endocrine:
- ☐ Hot Flashes
- ☐ Bothered by Heat
- ☐ High Thirst
- ☐ Bothered by Cold

Blood/ Lymph:
- ☐ Swollen Lymph Nodes
- ☐ Easy Bruising
- ☐ Easy Bleeding

PLACE PATIENT LABEL HERE