39 & Under History of Pregnancies, Hospitalizations, Surgeries

NAME____________________________ **DATE**__________________ **PAGE 1**

REASON FOR VIST: ☐ ROUTINE PHYSICAL ☐ PREGNANCY ☐ PROBLEM

DESCRIBE PROBLEM:

Total number of Pregnancies		*Number of Full-term births*		*Comments:*
Premature Births		*Abortions/Terminations*		
Miscarriages		*Living Children*		
Ectopic/Tubal Pregnancies				

PREGNANCIES GREATER THAN 12 WEEKS

Child's Name	*Baby's Sex*	*Birth Date*	*Weeks of Pregnancy*	*Delivery Type (Vaginal or C/S)*	*Early Labor?*	*Baby's Weight*	*Location City & State*	*Comments/ Complications*

HAVE YOU HAD A FLU SHOT OR IMMUNIZATION THIS YEAR? WHAT TYPE AND WHEN?

Immunization	*When*	*Immunization*	*When*	*Comments:*

Pap Smears/Mammograms/Bone Density Scans

					Comments:
When was your last Pap Smear? Where?			*Have you ever had a Mammogram? When?*		
Have you had an abnormal Pap? When?			*Have you had a bone density scan? When?*		
How was the abnormal Pap treated?			*Have you ever had the Chicken Pox?*		

PLEASE LIST ANY PAST INJURIES OR ILLNESSES:

TYPE	*DATE*	*COMMENTS*

PLEASE LIST ANY OPERATIONS OR HOSPITALIZATIONS YOU HAVE HAD:

SURGERY/REASON	*DATE/ WHERE*	*COMMENTS*

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FAMILY HEALTH HISTORY

Relative	*STATE OF HEALTH*	*YEAR BORN*	*AGE AT DEATH*	*CAUSE OF DEATH*	*COMMENTS*
FATHER					
MOTHER					
SISTERS (How Many)					
BROTHERS (How Many)					

PLEASE LIST ANY RELATIVES WITH BREAST, COLON, MELANOMA, UTERINE, CERVICAL OR OVARIAN CANCER

RELATIVE	*CANCER TYPE*	*AGE AT DIAGNOSIS*	*COMMENTS*

PLEASE LIST IN DETAIL FOR YOURSELF AND YOUR IMMEDIATE FAMILY:

DISEASE	*YOURSELF*	*IMMEDIATE RELATIVE (Be Specific Which Relative)*	*COMMENTS*
ALCOHOLISM			
ANXIETY/DEPRESSION			
ARTHRITIS			
BREAST CANCER			
BLADDER PROBLEMS			
BREATHING PROBLEMS			
DIABETES (TYPE 1 OR 2)			
DRUG ABUSE			
HEART DISEASE			
HIGH BLOOD PRESSURE			
HEPATITIS A, B, C			
MIGRAINES			
RHEUMATIC FEVER			
STROKE			
TUBERCULOSIS			
THYROID DISEASE (Hypo or Hyper)			

Use for 39 & Under History

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Gynecological History -- Please fill Out in Detail

Have you had a Hysterectomy? Type?	Yes	No	Vaginal	Abdominal
What age was your 1st Period?				
How many days is your cycle?(days from start of period to the next?)	____________days			
How long does your period last? Range	________ to________ days			
How heavy is your Period Flow?	Light	Medium		Heavy
Start of your last Period?	______/______/__________			
Do you have blood clots during your period?	Yes		No	
Do you have spotting or bleeding between periods?	Yes		No	
Do you have cramps during your periods?	Yes		No	
Do you have painful periods?	Yes		No	
What are you using for Birth Control?				
If not using Birth Control are you trying to get pregnant?	Yes		No	

Comments:

Social History -- Please fill Out in Detail

Please List Habits:

Alcohol?	Yes		No	
Drinks per?	Daily:	Weekly:	Monthly:	
Type?				
Drug Use?	Yes		No	
Types? Present or Past?				
Caffeine?	Yes		No	
Drinks per?	Daily:	Weekly:	Monthly:	
Currently Smoking?	Yes		No	
Packs Per Day?				
# of Years?				
Have you ever been a smoker?	Yes		No	
If so, how many years?				
Education Completed?	Elementary_ __yrs	Middle School _____yrs	High School _____Yrs	College _____yrs
What is your Occupation?				
How much do you exercise? Per week	None	1X	2-3X	4x or more
History of Abuse?	Yes		No	
Type?	Sexual	Emotional		Physical
Do you use your seatbelt?	Yes		No	
Marital Status?	Single	Engaged	Married	Divorced
	Domestic Partner		Separated	Widowed
Are you sexually active at this time?	Yes		No	
Type?	Men	Women		Both

Comments:

Allergies

Allergies to Medications/Food/Substance/Latex	Drug Reaction

Medications

Preferred Pharmacy:______________________ **City/State:**____________________

Drug Name	*Dosage*	*Physician Prescribing*	*Reason for taking*

List all "Natural" or Herbal remedies, over-the-counter drugs, vitamins or minerals you are taking:

Review of Systems

If you are currently experiencing any of these symptoms, please circle the symptom

Constitutional	Fatigue Weight Changes Night Sweats Hot Flashes Fever Body Aches Chills Change of Appetitie Additional Symptoms:________________________
Eyes	Vision Changes Discharge Discomfort Pain Double Vision Blurred Vision Eyelid Lesion Additional Symptoms:________________________________
HENT	Headaches Neck Tenderness Dizziness Lightheadedness Nasal Congestion Nose Bleeding Nasal Discharge Postnasal Drip Sinus Pain Hoarseness Neck Stiffness Neck Pain Thyroid Mass Oral Ulcers Sore Throat Breath Odor Decreased Hearing Tinnitus Additional Symptoms:______________________________
Breast	Lumps Tenderness Swelling Redness Nipple Discharge Additional Symptoms:___________________________
Cardiovascular	Lightheadedness Irregular Heartbeat Chest Pain Rapid Heart Rate Lower Extremity Edema Additional Symptoms:_________________
Respiratory	Shortness of Breath Wheezing Cough Hoarseness TB Exposure Additional Symptoms:____________________________
Gastrointestinal	Nausea Vomiting Diarrhea Constipation Loss of Appetite Heartburn Reflux Retching Excessive Bleeding Jaundice Abdominal Pain Blood in Stools Hemorroids Fatty Stools Excessive Flatulence Additional Symptoms:__________________
Genitourinary	Urgency of Urine Frequent Urination Painful Unrination Incontinence Vaginal Discharge Decreased Libido Irregular Menses Possible Pregnancy Genital Sores PMS Symptoms Change in Urine Color Difficulty Voiding Additional Symptoms:______________________
Integument	Rash Itching Pigmentation Changes Acne Skin Dryness Hair Growth Change Nail Changes New Skin Lesions Changes to Existing Skin Lesions Additional Symptoms:_________________________
Neurological	Seizures Tingling/Numbness Muscular Weakness Snoring Incoordination Loss of Balance Difficulty Concentrating Speech Difficulties Memory Difficulties Additional Symptoms:____________________
Musculoskeletal	Joint/Pain Swelling Muscle Pain Limitation of Motion Muscle Cramps Muscular Weakness Additional Symptoms:____________________
Endocrine	Loss of Hair Constipation Increased/Decreased Libido Acne Cold/Heat Intolerence Additional Symptoms:____________________
Psychiatric	Anxiety Depression Difficulty Sleeping Delusions Hallucinations Feeling Confused Compulsive Behaviors Impulsive Behaviors Suicidal Ideation Homicidal Ideation Excessive Anger Additional Symptoms:________________________
Heme/Lymph	Lightheadedness Easy Bleeding Easy Bruising Lymph Node Enlargement Additional Symptoms:_________________
Allergic/ Immunologic	Sinus Allergy Symptoms Frequent Illnesses Additional Symptoms:_________________