Bayspring Medical Group
INTERNAL MEDICINE & GYNECOLOGY

HEALTH HISTORY FORM

Name		**Today's Date**	
Date of Birth		**Age**	

REVIEW OF SYMPTOMS: Please check any current symptoms you have.

CONSTITUTIONAL

_____ Recent fevers/sweats
_____ Unexplained weight loss/gain
_____ Unexplained fatigue/weakness

EYES

_____ Change in vision

EARS/NOSE/THROAT/MOUTH

_____ Difficulty hearing/ringing in ears
_____ Hay fever/allergies/congestion
_____ Trouble swallowing

CARDIOVASCULAR

_____ Chest pains/discomfort
_____ Palpitations
_____ Short of breath with exertion

BREAST

_____ Breast lump
_____ Nipple discharge

RESPIRATORY

_____ Cough/wheeze
_____ Coughing up blood

GASTROINTESTINAL

_____ Heartburn/reflux
_____ Blood or change in bowel movement
_____ Nausea/vomiting/diarrhea
_____ Pain in abdomen

GENITOURINARY

_____ Painful/bloody urination
_____ Leaking urine
_____ Nighttime urination
_____ Discharge: penis or vagina
_____ Unusual vaginal bleeding
_____ Concern with sexual functions

MUSCULOSKELETAL

_____ Muscle/joint pain
_____ Recent back pain

SKIN

_____ Rash
_____ New or change in mole

NEUROLOGICAL

_____ Headaches
_____ Memory loss
_____ Fainting

PSYCHIATRIC

_____ Anxiety/stress
_____ Sleep Problem

BLOOD/LYMPHATIC

_____ Unexplained lumps
_____ Easy bruising/bleeding

ENDO

_____ Cold/heat intolerance
_____ Increase thirst/appetite

In the past month, have you had little interest of pleasure in doing things, or felt down, depressed or hopeless? ☐ Yes ☐ No

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.
If possible, please bring all your medications to your visit.

Medication / Dosage (e.g. mg/pill)	# times per day	Medication / Dosage (e.g. mg/pill)	# times per day

Allergies or reactions to medications:

Date of your most recent **IMMUNIZATIONS :**

Hepatitis A		Hepatitis B		Influenza (flu shot)	
MMR		Gardasil		Pneumovax (pneumonia)	
Meningitis		Tetanus		Tdap (tetanus & pertussis)	
Shingles Vaccine				Varicella (chicken pox) shot or illness	

HEALTH MAINTENANCE SCREENING TESTS:

Lipid (cholesterol)	Date:		Abnormal?	☐ Yes	☐ No
Sigmoidoscopy or Colonoscopy	Date:		Abnormal?	☐ Yes	☐ No
Dexascan (osteoporosis)	Date:		Abnormal?	☐ Yes	☐ No
Men: PSA (prostate)	Date:		Abnormal?	☐ Yes	☐ No

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problem (with dates).

________ Heart disease:
Specify type ______________________

________ Cancer:
Specify: _________________________

________ Kidney disease

________ High blood pressure

________ Diabetes

________ Asthma/Lung disease

________ Previous blood transfusion

________ High cholesterol

________ Thyroid problem

________ Other:
Specify: _________________________

SURGICAL HISTORY: Please list all prior operations (with dates):

____

____

____

FAMILY HISTORY: Please indicate the current status of your immediate family members:
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism: ____________________________________

Cancer, specify type: ____________________________

Heart disease: __________________________________

Depression/suicide:______________________________

Genetic disorders: _______________________________

Diabetes: ______________________________________

High cholesterol: ________________________________

High blood pressure: _____________________________

Stroke: ____

Bleeding or clotting disorder: _____________________

Asthma/COPD: __________________________________

Other: ____

SOCIAL HISTORY:

Tobacco Use

Cigarettes ☐ Never ☐ Quit Date: ______________

☐ Current Smoker: packs/day _______ # of years _________

Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Are you interested in quitting? ☐ Yes ☐ No

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No # drinks/week ________

Is your alcohol use a concern for you or others? ☐ Yes ☐ No

Drug Use

Do you use any recreational drugs? ☐ Yes ☐ No

Have you ever used needles to inject drugs? ☐ Yes ☐ No

Sexual Activity

Sexually active: ☐ Yes ☐ No ☐ Not currently

Current sex partner(s) is/are: ☐ Male ☐ female

Birth control method: ________________ ☐ None needed
Past Method: ____________________________________

Have you ever had any sexually transmitted diseases (STDs)?
☐ Yes ☐ No

Are you interested in being screened for sexually transmitted diseases? ☐ Yes ☐ No

OTHER CONCERNS:

Caffeine Intake: ☐ None ☐ Coffee/tea/soda ______ cups/day

Weight: Are you satisfied with your weight? ☐ Yes ☐ No

Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Do you eat or drink four servings of dairy or soy daily or take calcium supplements? ☐ Yes ☐ No

Exercise: Do you exercise regularly? ☐ Yes ☐ No

What kind of exercise? ______________________________

How long (minutes) ___________ How often? ______________

If you do not exercise, why? __________________________

Safety: Do you use a bike helmet? ☐ Yes ☐ No

Do you use seatbelts consistently? ☐ Yes ☐ No

Is violence at home a concern for you? ☐ Yes ☐ No

Have you ever been abused? ☐ Yes ☐ No

Do you have a gun in your home? ☐ Yes ☐ No

Do you have an earthquake kit? ☐ Yes ☐ No

Have you completed a living will or durable power of attorney for Health care? ☐ Yes ☐ No

WOMEN'S HEALTH HISTORY:

Age at first menstruation: _________ Do you have regular periods: ☐ Yes ☐ No

How often do you menstruate (e.g. "every 28 days") ________ Length of menstruation in days ____________

# of pregnancies (total) ________ # of deliveries _________ # of miscarriages _________ # of abortions _________

Methods of delivery/complications ____

Last Mammogram: (year) ____________ Abnormal? ☐ Yes ☐ No

Last Pap smear: (year) ____________ Have you ever had an abnormal pap smear? ☐ Yes ☐ No If yes, (year) ____________

Treatment: ____

Estrogen therapy in past? ☐ Yes ☐ No