

## Medical History Form

Name: \_\_\_\_\_  
DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_

Preferred name: \_\_\_\_\_

Pronouns: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Other health care providers including naturopathic, chiropractic, etc.:  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any medications? If yes, please list name and type of reaction (ex: Penicillin, Rash):  
\_\_\_\_\_  
\_\_\_\_\_

Are you allergic to any of the following?

Latex  Iodine  Nickel  Betadine

List Current medications/supplements:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Immunizations, list date of most recent vaccine if know (ex: Tetanus, 1/12/20):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgeries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current living situation (ex: with partner and child):  
\_\_\_\_\_  
\_\_\_\_\_

Smoking and/or tobacco use:

Never

Past/Date quit: \_\_\_/\_\_\_/\_\_\_ Age started \_\_\_\_\_

Packs per day: \_\_\_\_\_

Do you use E-cigarettes/vape?  No  Yes

Alcohol use:  No  Yes, how many drinks per week? \_\_\_\_\_ Type: \_\_\_\_\_

Drug use (ex: marijuana, cocaine, narcotics):

Never  Past  Present

If yes, what type of drug? \_\_\_\_\_

If yes, how often? \_\_\_\_\_

How often do you exercise/type (ex: 2-3x/week, cardio, yoga):  
\_\_\_\_\_  
\_\_\_\_\_

First day of last menstrual period: \_\_\_/\_\_\_/\_\_\_

Is your period usually:

Light  Moderate  Heavy

Is your period regular/irregular? \_\_\_\_\_

How many days do your period last? \_\_\_\_\_

Menopausal, if yes, date of last period: \_\_\_/\_\_\_/\_\_\_

How many of the following have you had?

Pregnancies \_\_\_ Live births \_\_\_ Still Living \_\_\_  
C-sections \_\_\_ Miscarriages \_\_\_ Abortions \_\_\_  
Still births \_\_\_ Tubal Pregnancies \_\_\_

Plans for future pregnancies?

Yes  No  Undecided

Have you ever been sexually active:  No  Yes

If yes, how many partners within the past year? \_\_\_

Men  Women  Both

What do you currently use for birth control?

None  Condoms  Pills  Vasectomy

Other: \_\_\_\_\_

Have you ever had any sexually transmitted disease?

No  Yes, type? \_\_\_\_\_

**Have you ever had any of the following? (Check all that apply)**

- Abnormal Pap    Fibroids    Endometriosis    Infertility    Ovarian Cyst

**Personal Medical History (please check if you have had any of the following):**

- Anemia    Asthma    Stroke    Thyroid Problems    Depression/Anxiety    Mental Illness
- High blood pressure    Heart problems    Kidney problems    Kidney Stones    Migraines
- Blood clots    Osteoporosis    Diabetes/Type: \_\_\_\_\_    Cancer/Type: \_\_\_\_\_
- Hepatitis/type: \_\_\_\_\_    Genital Herpes    Pain/problems with sex    Other: \_\_\_\_\_

	Date	Where	Results(normal/abnormal)
Pap Smear			
Annual Exam			
Bone Density scan			
Colonoscopy			
Mammogram			

Has anyone in **your family** ever had any of the following?

	Relative(s) ( ex: children, parents, grandparents)
Osteoporosis	
Breast Cancer	
Ovarian Cancer	
High Blood Pressure	
High Cholesterol	
Stroke or Blood Clot	
Melanoma	
Diabetes	
Heart Attack under age 50	
Alcoholism	
Mental Health Problems	
Thyroid Disease	
Colon Cancer	
Other	

Do you ever feel like you are verbally or emotionally abused?  Yes    No

Are you in a relationship where you are being slapped, hit, or kicked?  Yes    No

Are you forced to have sex when you don't want to?  Yes    No

Do you feel you have a problem with drugs or alcohol?  Yes    No

Do you think you have an eating disorder like bulimia or anorexia?  Yes    No

Are you getting counseling right now?  Yes    No

**Signature:** \_\_\_\_\_