Reiter, Hill, & Johnson P.L.L.C.

DATE ___________

NAME _______________________________
OCCUPATION _______________________
DATE OF BIRTH _____________________
MARITAL STATUS ___________________
ETHNICITY__________________________

MEDICAL HISTORY

Have you had any of the following?:

HEART PROBLEMS ____
MITRAL VALVE PROLAPSE ______________________________________
HIGH BLOOD PRESSURE ____
STROKE/TIA____
RHEUMATIC FEVER ____
HIGH CHOLESTEROL ____
DIABETES ____
ASTHMA OR OTHER LUNG PROBLEMS _______________________________
THYROID DISEASE ____
DIFFICULTY CLOTTING/BLEEDING ABNORMALITIES____________________
ANEMIA ____
THROMBOPHLEBITIS____
PULMONARY EMBOLISM____
BOWEL/GASTROINTESTINAL PROBLEMS _____________________________
CANCER ____
CONNECTIVE TISSUE DISORDERS _________________________________
TUBERCULOSIS ____
UNUSUAL INFECTIONS ____
HIV/AIDS ____
LIVER DISORDERS/HEPATITIS ___________________________________
MIGRAINE HEADACHES ____
KIDNEY PROBLEMS ____
FREQUENT BLADDER INFECTIONS _________________________________
OSTEOPOROSIS/OSTEOPENIA ____________________________________
DEPRESSION /ANXIETY DISORDERS _______________________________
EATING DISORDERS ____
MISCELLANEOUS____

Have you had or have you been vaccinated against?:

RUBELLA (GERMAN MEASLES) ___________________________________
VARICELLA (CHICKEN POX) ____________________________________
HEPATITIS B ____
GARDASIL/HPV____

FAMILY HISTORY

Is there a family history of?:

HEART DISEASE ____
HIGH BLOOD PRESSURE ____
HIGH CHOLESTEROL ____
DIABETES ____
CANCER____
BREAST____
OVARIAN____
OTHER____
BLOOD CLOTTING DISORDERS ____________________________________
CONGENITAL ANOMALIES/GENETIC DISORDERS _______________________
OSTEOPOROSIS ____
DEPRESSION ____
ALCOHOL ABUSE ____
STROKES ____
GYNECOLOGIC DISORDERS (FIBROIDS, ENDOMETRIOSIS, ETC.)_______________

Reviewed by ____________________

NAME _________________________

MEDICATIONS

Please list any medications including over the counter medications, vitamins, and herbs and the corresponding dosages

_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

SURGICAL HISTORY

Operation	Year	Hospital/Physician	Findings/Complications

ALLERGIES

Please list any drug allergies or sensitivities and their corresponding reactions as well as significant food or skin allergies (i.e. latex, peanuts, shellfish):

Drug **Reaction** ____

____
____
____

SOCIAL HISTORY

Do you smoke cigarettes?_________________ How much? _______________________ How long? ______________
Do you drink alcohol?____________________ How much?_______________________ How often?______________
Do you use recreational drugs?________________ Which ones?__________________ How often?_______________
Do you use seatbelts regularly?____
Are you afraid of or are you being threatened by a current or former partner? ___________________________________
Within the last year have you been hit, slapped, kicked, forced into sexual activity, or otherwise physically hurt by a current or former partner? ____
Do you have any dietary restrictions? (vegetarian, lactose-free, low fat, low salt, Kosher, etc.)?____________________
Do you get adequate calcium (1000 – 1500 mg/day) in your diet?____
What do you do for exercise?___________________ How often?_________________ How long?________________
Are you sexually active?___________________ If so, how many partners have you had in the past year?____________
Sexual orientation?____
Have you ever had a blood transfusion? If so, please explain.____
Do your religious beliefs prohibit your acceptance of blood transfusions?_______________________________________
Have you had any stress related and/or psychiatric problems?____
Therapy/counseling____
Depression/Anxiety disorders____
Abuse: mental, physical, sexual____
Substance abuse____
Other____

Reviewed by ___________________________

NAME________________________

OBSTETRICAL HISTORY (including deliveries, miscarriages, ectopics, and abortions)

Year	Name	Hospital or Physician	Duration of Pregnancy	Sex	Weight	Length of Labor	Type of Delivery	Complications

MENSTRUAL HISTORY

Last Menstrual Period________________________________Was it normal?____________________________
Menarche (age of first period)____
Frequency (number of days from start of one period to start of next period)_____________________
Duration____
Amount (light, moderate, heavy or number of pads/tampons per day)__________________________
Do you have problems with:
- **Menstrual cramps____**
- **Abnormal or irregular bleeding____**
- **PMS (Premenstrual Syndrome)____**
- **Menopausal symptoms____**

GYNECOLOGIC HISTORY

When was your last pap smear?____________________________ Result?____________________________
Sexually Transmitted Infections____
- **Gonorrhea____**
- **Chlamydia____**
- **Syphilis____**
- **HPV/Genital Warts____**
- **Herpes____**
- **HIV/AIDS____**
- **Tubal Infection (PID)____**

Abnormal discharge or recurrent vaginal infections____
- **Yeast (monilia)____**
- **Gardnerella/Bacterial vaginosis____**
- **Trichomonas____**

B-Streptococcus ____
Abnormal pap smear___________________________ When?______________________________________
- **Colposcopy____**
- **Cryotherapy________________________________ Laser therapy__________________________**
- **LEEP_____________________________________ Cone biopsy_____________________________**

Polycystic Ovarian Syndrome (PCOS)____
Fibroids____
Endometriosis____
Infertility____
Pain or other problems with intercourse____
Have you ever had a DEXA scan?___________________________If so, when?____________________________
Breast problems____
- **Fibrocystic changes_________________________________ Pain_____________________________**
- **Nipple discharge___________________________________ Lumps____________________________**
- **Biopsy____ Cancer___________________________**
- **Do you perform breast self exams?______________________ If so, how often?_______________**
- **When was your last mammogram?____**

Reviewed by ____________________

NAME_________________________

CONTRACEPTIVE HISTORY

Method	Dates	Complications
Tubal Ligation		
Vasectomy		
Intrauterine device (IUD)		
Birth control pills		
Norplant		
Depo Provera		
Implanon		
Vaginal Ring (NuvaRing)		
Contraceptive Patch (Ortho Evra)		
Sponge		
Rhythm		
Foam, cream, jelly		
Withdrawal		
Diaphragm		
Condoms		

MISCELLANEOUS

Did your mother receive hormones (DES) during her pregnancy with you?

Patient signature ____

Reviewed by ____________________