Sandpoint Women's Health
New Patient Health History Form

Patient Name:_____ Date: _____

Reason for visit: _____ Age/Date of Birth: _____

Primary Care Provider: _____ Marital Status:_____

PAST MEDICAL HISTORY: Check all that apply

_____ Asthma	_____ Epilepsy/Seizures	_____ Kidney/Liver Disease
_____ Blood Clots	_____ Heart Disease	_____ Migraines
_____ Depression	_____ High Blood Pressure	_____ Osteoporosis
_____ Diabetes	_____ High Cholesterol	_____ Thyroid Disease

Any other health issues: _____

GYNECOLOGIC/OBSTETRIC HISTORY: Have you ever had any of the following? (Check all that apply.)

_____ Abnormal Pap Smear	_____ Genital Warts	_____ Infertility
_____ Endometriosis	_____ Gonorrhea or Chlamydia	_____ Pelvic Inflammatory Disease
_____ Fibroids	_____ Herpes	_____ Pelvic Pain/Pressure/Bloating
_____ Frequent Bladder Infections	_____ HIV	_____ Urinary Incontinence

Check if you are up to date with the following vaccinations and the year received:

_____ Flu	_____ Pneumonia	_____ Tdap
_____ Hepatitis B	_____ Rubella (measles)	_____ Tetanus

SURGICAL HISTORY: Write year and type of surgery.

_____

_____

Current medications and supplements: _____

_____

Medications you are allergic to:_____ Y / N Latex Y / N Eggs Y / N Iodine

FAMILY MEDICAL HISTORY: Mark M for Mother, F for Father, S for Sister, B for Brother, A for Aunt, U for Uncle, PGP for Paternal Grandpa, PGM for Paternal Grandma, MGP for Maternal Grandpa, and MGM for Maternal Grandma. **Add ages if possible.**

_____ Blood Clots	_____ High Cholesterol	_____ Uterine Cancer
_____ Breast Cancer	_____ Melanoma	**Other**:_____
_____ Colon Cancer	_____ Osteoporosis	_____
_____ Diabetes	_____ Ovarian Cancer	
_____ Heart Attack	_____ Prostate Cancer	
_____ High Blood Pressure	_____ Stroke	

BASIC OB/GYN INFORMATION:

_____ Age of first period	_____ Number of Pregnancies
_____ First day of last period	_____ Full Term / Premature deliveries
_____ Length of menstrual cycles	_____ Number of abortions
_____ Length of each period	_____ Number of miscarriages
_____ Heavy periods?	_____ Number of living children
_____ Painful periods?	_____ Last Mammogram
_____ Last Pap smear	_____ Last Colonoscopy

Are you planning a pregnancy in the next year? _____

If applicable, what are you using for birth control? _____

Do you have any questions/concerns about your sexual life? _____

PERSONAL HEALTH HISTORY:

Occupation: _____ What do you do for exercise? _____

Have you ever been physically, emotionally, or sexually abused?_____

Do you drink alcohol? ☐ Y ☐ N Amount _____ daily _____ weekly _____ monthly

Do you use tobacco? ☐ Former ☐ Never ☐ Current – amount used _____

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New Patient Health History Form – Continued

Name: _____ DOB: _____

REVIEW OF SYSTEMS - Please circle any symptoms that have troubled you during the last several weeks.

General	Fatigue	Unexplained weight loss	Unexplained weight gain
Eyes	Vision problems		
ENT	Sore throat Headache	Sinus congestion Nasal discharge	Ear ache
Cardiovascular	Chest pain	Heart palpitations/flutters	Swelling in feet
Respiratory	Cough Coughing up blood	Shortness of breath	Wheezing
GI	Nausea Diarrhea Rectal bleeding Abdominal pain	Vomiting Constipation Black, tarry stools	Heartburn Bloating Hemorrhoids
GU	Blood in urine Heavy periods Vaginal discharge	Painful urination Bleeding between periods Pelvic pain	Leaking of urine Bleeding with intercourse
M-S	Muscle aches	Joint aches	
Skin/Breast	Skin rashes	Breast pain	Breast discharge
Neurologic	Headache Fainting	Seizures Weakness	Numbness
Psychiatric	Depression	Anxiety	
Endocrine	Heat intolerance Night sweats	Cold intolerance	Hot flashes
Heme/Lymph	Easy bruising	Swollen glands	
Immun/Allergy	Seasonal allergies	Fevers	Chills

☐ Check here if none of the above apply.

BONNER GENERAL HEALTH
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