

SWEDISH COVENANT MEDICAL ASSOCIATES
Personal Health History Form
NMS

PATIENT LABEL

DATE: _____

REFERRED BY: _____

PRIMARY DOCTOR: _____

PREFERRED LANGUAGE: _____

ALLERGIES None

REASON FOR TODAY'S VISIT

PERSONAL INFORMATION

Age: _____ Birth Date: _____ Marital Status: Married Single Divorced Widowed

Current or most recent occupation: _____

GYNECOLOGICAL HISTORY

First day of your last Menstrual Period: ____/____/____

Date of your last Pap Test: ____/____/____

Results : Normal Abnormal (Please circle one)

If abnormal, explain: _____

Have you ever had an abnormal Pap Test? Yes No

If yes, explain: _____

Age of your first period: _____

Length of your period: _____ (Number of bleeding days)

Number of days between each period: _____

Have you had any menstrual problems? Yes No

If yes, explain: _____

Are you in a sexual relationship? Yes No

Are there any sexual problems? Yes No

If yes, explain: _____

Sexual Partners are: Men Women Both

Total number of sexual partners in your lifetime: _____

Method of birth control: Presently _____ In the Past _____

Date of Last Mammogram: ____/____/____

Date of Last Bone Scan : ____/____/____

Any Breast Biopsies: Yes No If yes, dates: _____

PAST PREGNANCIES:

DATE MONTH/ YEAR	# GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	SEX M/F	TYPE OF DELIVERY: VAGINAL or C-SECTION	EPIDURAL YES / NO	PLACE OF BIRTH	PRETERM LABOR YES / NO	MISCARRIAGE ABORTION ECTOPIC TUBAL (PLEASE SPECIFY)	PRENATAL COMMENTS /COMPLICATIONS: i.e. Hypertension / Diabetes / Hemorrhage post partum

Medications:	None <input type="checkbox"/>		
Name	Dosage	Name	Dosage

MEDICAL HISTORY:ILLNESS	NO	YES	NO	YES
Diabetes			Heart Disease	
High Blood Pressure			Stroke	
Sexually Transmitted Diseases			Headaches/Migraines	
Osteoporosis/Bone Disease			Seizures	
Thyroid Disease			Asthma/Lung Disease	
Urinary Tract Infections			Kidney Infections/Stones	
Blood Clots in Lungs or Legs			Ulcers/Reflux	
Depression/Anxiety			Bowel Problems	
Cancer			Hepatitis/Liver Disease	
Anemia			Gall Bladder Disease	

SURGERIES	<input type="checkbox"/> None	
DATE	SURGERY	ANY COMPLICATIONS

SOCIAL HISTORY		YES	NO		
Tobacco	<input type="checkbox"/> Past			<i>Packs per day:</i>	<i>Years:</i>
	<input type="checkbox"/> Present			<i>Packs per day:</i>	
Alcohol	<input type="checkbox"/> Past			<i>Drinks per week:</i>	<i>Years:</i>
	<input type="checkbox"/> Present			<i>Drinks per week:</i>	
Drugs	<input type="checkbox"/> Past			<i>Type of Drug:</i>	<i>How used:</i>
	<input type="checkbox"/> Present			<i>Type of Drug:</i>	<i>How used:</i>
Have you ever been sexually, physically or verbally abused?				By Whom?	Currently?
Supplements / Herbals				Quantity:	Dose:
Health Hazards at Home/Work					
Seat Belt Use					
Folic Acid Intake					
Calcium Intake					
Caffeine Intake					
Other					
Diet (check any that apply): <input type="checkbox"/> Vegan <input type="checkbox"/> Vegetarian <input type="checkbox"/> Lactose Intolerant <input type="checkbox"/> Other explain:					
Regular Exercise: Type				How Often:	

FAMILY HISTORY (FH):							
Mother: <input type="checkbox"/> Living <input type="checkbox"/> Deceased				Father: <input type="checkbox"/> Living <input type="checkbox"/> Deceased			
Cause:		Age:		Cause:		Age:	
Siblings: Number Living:		Number Deceased:		Cause:			
FAMILY HISTORY	Yes	No	Relationship		Yes	No	Relationship
Breast Cancer				Stroke			
Colon Cancer				Heart Disease			
Ovarian Cancer				High Blood Pressure			
Uterine Cancer				High Cholesterol			
Cancer Other				Birth defects or Mental Retardation			
Blood Clots in Legs or				Alcoholism or Drug Abuse			
Osteoporosis				Alzheimer's Disease			
Diabetes				Other			

REMAINDER TO BE COMPLETED BY PROVIDER

New Patient
 Established Patient
 Consultation

Primary Care Physician:	Who Sent Patient:
Other Physician(s):	
Last Colorectal Screening Date: / /	

Review of System (ROS) :	
1. Constitutional	<input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Fatigue
2. Eyes	<input type="checkbox"/> Vision Change
3. Cardiovascular	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations or Irregular Heartbeat
4. Respiratory	<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Cough
5. Gastrointestinal	<input type="checkbox"/> Bloody Stool <input type="checkbox"/> Involuntary loss of gas or stool <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation
6. Urinary	<input type="checkbox"/> Frequency of urination <input type="checkbox"/> Bloody Urine <input type="checkbox"/> Painful Urination <input type="checkbox"/> Urgency to Urinate <input type="checkbox"/> Incomplete Emptying <input type="checkbox"/> Involuntary Loss of urine
7. Pelvic	<input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Pelvic Pressure <input type="checkbox"/> PMS <input type="checkbox"/> Abnormal/Painful Periods
8. Breast	<input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Breast Lump <input type="checkbox"/> Breast Tenderness
9. Psychiatric	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression
10. Endocrine	<input type="checkbox"/> Hot Flashes <input type="checkbox"/> Abnormal thirst <input type="checkbox"/> Hair Loss <input type="checkbox"/> Heat/Cold Intolerance <input type="checkbox"/> Dry Skin

PATIENT SIGNATURE: _____ DATE _____

PATIENT COUNSELED: _____ DATE _____

PHYSICIAN SIGNATURE: _____ DATE _____