

Health History Update

Name _____ Date of birth _____ Age _____

To help your provider during today's exam, please note any **changes** in your status since your last exam.

1. Social system

Occupation and work environment: _____

Education: _____

Relationship status: _____

Members in household: _____

2. Medication history

List any current medications and usage (including over-the-counter and vitamins/herbs/supplements):

Medication	Dosage	Frequency	Use

Are you allergic to any medications/foods/agents?

Medication/Food/Agent	Reaction

3. Menstrual history

First day of last menstrual period: _____

of days between periods: _____

Length of each period: _____

List any problems with your periods: _____

If menopausal, age when periods stopped: _____

List any current menopausal symptoms: _____

4. Sexual system

Are you currently sexually active? _____

Current sex partner(s) is/are: male ___ female ___

How long have you been sexual with your partner(s)? _____

of sexual partners in the last year? _____

Are you experiencing any sexual, verbal or physical abuse? _____

5. Contraceptive system

If you are currently using birth control, what method do you use? _____

Are you planning a pregnancy this year? _____

6. Medical history

List any changes in your health since your last exam:

7. Family medical history (parents, siblings, or grandparents only)

List any changes in your family's health:

8. Substance use

of mixed drinks, beer, or wine/week _____

Is alcohol a concern for you or others? _____

Cigarette use: _____ #/day

Are you interested in quitting? _____

Do you use any recreational drugs? _____

If yes, what and when? _____

of caffeinated beverages daily: _____

9. Preventive health

Date of last Pap test: _____

Date of last mammogram: _____

Do you do monthly self-breast exams? _____

When was your last dental exam? _____

Eye exam? _____

Colonoscopy? _____

Bone density scan? _____

Type and frequency of exercise _____

Please describe your appetite/eating habits:

Do you eat 4 servings of dairy products a day or take 1000-mg. calcium supplement? _____

Do you always wear a seat belt? _____

Does your house have a smoke detector? _____

Do you have any firearms at home? _____

When was your last tetanus shot? _____

Have you had your cholesterol level checked within the last 5 years? _____ Date: _____

10. Current concerns

Do you have any questions, problems, or concerns?
