



# JOHNSON COUNTY OB/GYN CHARTERED Health History

Date \_\_\_\_\_

## Identification

NAME: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Chief Complaint \_\_\_\_\_ Date of Onset \_\_\_\_\_

Progression of symptoms: \_\_\_\_\_

Frequency of Symptoms: \_\_\_\_\_

What relieves or initiates symptoms: \_\_\_\_\_

## Past Medical History

- Measles
- Mumps
- Anemia
- Diabetes
- Sinusitis
- Stroke
- Angina
- Cancer - type, location, treatment \_\_\_\_\_
- Polio
- Gout
- Arthritis
- Headaches
- Colitis
- Epilepsy
- Heart Problems
- Goiter
- Ulcers
- Asthma
- Jaundice
- Kidney Infection
- Vision Problems
- Stroke
- Hiatal Hernia
- Gastritis
- Bronchitis
- Hepatitis
- Kidney Stone
- Clotting Problems
- Cataracts
- Chlamydia
- Polyps
- Gallstones
- Bowel Obstruction
- Syphilis
- Gonorrhea
- Heart Attack
- Herpes
- Hemorrhoids
- Fissure-Abscess
- Varicose Veins
- Phlebitis
- Mental Illness
- Sexual Problem
- Drug Problem
- HIV

### HOSPITALIZATIONS: (surgeries, outpatient treatments, etc.)

DATE	HOSPITAL	DIAGNOSIS	TREATMENT	PHYSICIAN
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Comments: \_\_\_\_\_

### GYNECOLOGICAL HISTORY:

PREGNANCIES:	Year	Weight	Sex	Type of Delivery	Complications
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

GYNECOLOGICAL SURGERIES: \_\_\_\_\_

BIRTH CONTROL:  Tubal Ligation  Vasectomy  Menopausal  None Needed  Birth Control Pills (name) \_\_\_\_\_  Other \_\_\_\_\_

## Allergies

Agent	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

## Current Medications

Medication Name	Dosage	Frequency	Duration
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# Review of Systems

(Check those which have occurred recently)

## GENERAL

- Weight Gain
- Weight Loss
- Weakness
- Fever
- Night Sweats

## SKIN

- Color Changes
- Nail Changes
- Hair Changes
- Mole Changes
- Sores

## EYES

- Blurred Vision
- Cataracts
- Glaucoma
- Pain
- Swelling

## EARS

- Hard of Hearing
- Deafness
- Discharge
- Loss of Balance
- Earache

## NOSE

- Bleeding
- Pain
- Obstruction
- Sinus
- Discharge

## MOUTH

- Bleeding
- Sores
- Pain
- Ulcers
- Blisters

## NECK

- Enlargement
- Stiffness
- Lumps
- Masses

## BREASTS

- Discharge
- Lumps
- Pain
- Bleeding
- Nipple Changes
- Skin Changes

## LUNGS

- Cough
- Coughing Blood
- Wheezing
- Pain
- Asthma
- Congestion

## HEART

- Murmur
- Palpitations
- Rapid Beat
- Chest Pain
- Chest Pressure
- Varicose Veins

## BLOOD

- Anemia
- Easy Bruising
- Swollen Nodes
- Easy Bleeding
- Blood Clots

## PSYCHIATRIC

- Anxiety
- Depression
- Irritability
- Drug Problem

- Abdominal Pain
- Nausea
- Vomiting
- Bloating
- Heartburn
- Constipation
- Date of Last Colonoscopy \_\_\_\_\_
- Date of Last Hemacult Test \_\_\_\_\_

- Diarrhea
- Gas
- Hemorrhoids
- Poor Appetite
- Bloody Stools
- Black Stools

## GENITOURINARY

- Urgency
- Incontinence
- Straining
- Void Frequently
- Burning
- Infection in Bladder
- Date of Last Bladder Infection \_\_\_\_\_
- Small Stream
- Discharge
- Sores
- Dribbling
- Cloudy Urine

## GYNECOLOGICAL

- Spotting
- Irregular Flow
- Lack of Flow
- Other
- Cramps
- Endometriosis
- Sexual Problems
- Discharge
- Infertility
- Infections
- Abnormal Pap Smear
- Pain with Intercourse
- Hot Flashes
- Fibroids
- Ovarian Cysts

Menstrual History: Age 1st period \_\_\_\_\_ Date of last period \_\_\_\_\_

Length of flow \_\_\_\_\_ days      Length of time between periods \_\_\_\_\_ days

Character of flow \_\_\_\_\_ (heavy, light, clots, etc.)

# Family History

(family history of cancer [breast, colon, uterine, etc.], heart disease, osteoporosis, etc.)

RELATIONSHIP	ILLNESS	TREATMENT	CURRENT STATE OF HEALTH
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# Social History

Marital Status:  Single    Married    Divorced    Widowed

Alcohol use: \_\_\_\_\_ (amount per week)      Caffeine use: \_\_\_\_\_ (cups per day)

Smoking use: \_\_\_\_\_ (pack per day)      \_\_\_\_\_ years      \_\_\_\_\_ date quit

Exercise:  None    Light    Moderate    Heavy      Nutrition:  Poor    Fair    Good

Date of last mammogram \_\_\_\_\_      Date of last PAP smear \_\_\_\_\_      Calcium intake \_\_\_\_\_ gms/day

Over-the-counter medications: (doses per week) \_\_\_\_\_ Vitamins \_\_\_\_\_ Aspirin \_\_\_\_\_ Advil \_\_\_\_\_ Laxatives \_\_\_\_\_ Other \_\_\_\_\_

COMPLETED BY: \_\_\_\_\_ Date: \_\_\_\_\_