

Please complete the following information as accurately as possible. Your answers on this form will help your provider understand your medical concerns and conditions better. If you cannot remember specific details, please give best estimates.

We realize that this is a very lengthy form, but we are asking for you to provide a comprehensive history for our Electronic Health Record which results in improved care for you.

We ask that you arrive at your appointment with the forms completed.

This can also be done on-line with our Patient Portal. If you would like to use this option visit www.afwmedicine.com and complete on-line. This will facilitate your appointment.

Name:		Age:	Date:
Employer:		Emergency Contact Name:	Emergency Contact Phone:
Occupation:		Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Married <input type="checkbox"/> Married Again <input type="checkbox"/> Single <input type="checkbox"/> Widowed	
1.	What is the reason for your visit? _____ _____ _____		
2.	Present Health Concerns: _____ _____ _____		
3.	Health Maintenance Screening Tests:		
	Lipid (Cholesterol Screening) Date: _____ Results: _____		
	Mammogram Date: _____ Results: _____ Ever Abnormal? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what was abnormal? Please describe: _____ _____		
	Pap Smear Date: _____ Results: _____ Ever Abnormal? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date _____ what was abnormal? _____ History of HPV? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date _____ Colposcopy? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date _____ Results _____ LEEP? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date _____ Results _____ Have you received the HPV vaccine, Gardasil? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date _____		
	Stool test for blood Date: _____ Results: _____		
	DEXA Scan Date: _____ Results: _____		
	Colonoscopy Date: _____ Results: _____		

NAME:

4. Your Personal Medical History

Check if you had any of these medical problems in the past:

MAJOR ILLNESSES	YES	MAJOR ILLNESSES	YES
Alcoholism		Heart Murmur	
Anemia		Hepatitis/Jaundice	
Anxiety		High Blood Pressure	
Arthritis/Joint Pain		High Cholesterol	
Asthma		Kidney Infections	
Blood Clot/DVT		Kidney Stones	
Blood Transfusions		Migraines	
Bowel Trouble		Mood Disorders	
Breast Cancer		Osteopenia	
Cancer – List type:		Osteoporosis	
Chronic Lung Disease		Ovarian Cancer	
Depression/Suicide Attempt		Pneumonia	
Diabetes		Rheumatic Fever	
Fibroids		Sexually Transmitted Diseases	
Fracture		Stroke	
GERD		Tuberculosis – TB	
Glaucoma		Thyroid Disease	
Heart Disease		Ulcers	

Other problems not listed above:

Where you have indicated "YES" please provide details below:

5. Past Surgical History

Year	Illness or Operation	Complications?

6. Allergies (Drugs, Food, Environmental)

Reactions

7. Current Medications: Prescriptions and non-prescription medicine, vitamins, home remedies, birth control pills, herbs;

Medication	Dosage	Frequency	Date prescribed	By who?

NAME:

8. Family History: Please indicate below significant medical problems of family members. Indicate which family members by checking the appropriate column **AND THE AGE OF ONSET.**

	None	Mother	Father	Brother	Sister	Grandmother (Maternal)	Grandmother (Paternal)	Grandfather (Maternal)	Grandfather (Paternal)	Aunt	Uncle
Blood Clots											
Breast Cancer											
Cervical Cancer											
Colon Cancer											
Diabetes											
Elevated Cholesterol											
Endometriosis											
Heart Disease											
Hypertension											
Osteoporosis											
Ovarian Cancer											
Stroke											
Thyroid Disease											
Other cancer not mentioned:											
Other disease not mentioned:											

9. Reproductive History

Age at first period:	1 st day (date) of most recent period:
Frequency of periods:	Describe Period: <input type="checkbox"/> Normal <input type="checkbox"/> Light <input type="checkbox"/> Heavy Number of Heavy days _____
Length of each period:	Are you in menopause: <input type="checkbox"/> No <input type="checkbox"/> Yes: Date of Last period _____
Current Contraceptive Method: Please describe	
Do you have concerns about your period? <input type="checkbox"/> No <input type="checkbox"/> Yes: Please describe	

	Number		Number
Total # of Pregnancies		Abortions Induced	
Full Term Births		Miscarriages	
Pre Term Births		Living Children	

On the chart below, please fill in answers for each pregnancy including abortions or miscarriages.

No.	Birth Date	Wks Gest	Labor (hrs)	Baby's Weight/Sex	Del Type Vag/CSection	Anes.	Early Labor?	Wt Gain	Comments/Complications	Location
1				M F						
2				M F						
3				M F						
4				M F						
5				M F						
6				M F						

NAME:	
10. Social History	
Sexual Activity	Are you sexually active: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not currently
	Current sex partner(s) is/are: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Have you had more than 5 sexual partners in your lifetime? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever had any sexually transmitted diseases? (STDs)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which one(s) _____
	Interested in being screened for sexually transmitted diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No
Caffeine Intake	<input type="checkbox"/> None <input type="checkbox"/> Coffee/Tea: # _____ cups per day <input type="checkbox"/> Chocolate _____ oz. per day <input type="checkbox"/> Sodas: _____ oz. per day
Alcohol Use	<input type="checkbox"/> No <input type="checkbox"/> Yes Drinks per week: _____ Is alcohol use a concern for you or others? <input type="checkbox"/> No <input type="checkbox"/> Yes
Drug Use	Do you use recreational drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever used needles? <input type="checkbox"/> No <input type="checkbox"/> Yes
Tobacco Use	Cigarettes: <input type="checkbox"/> Never <input type="checkbox"/> Quit: Date: _____
	<input type="checkbox"/> Current Smoker, packs per day _____ Number of years: _____
	<input type="checkbox"/> Former Smoker, packs per day _____ Number of years: _____
	Other Tobacco: _____ Are you interested in quitting? <input type="checkbox"/> No <input type="checkbox"/> Yes
Safety	Do you use seatbelts consistently? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Is violence at home a concern for you? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever been abused? <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet	Do you take supplements? <input type="checkbox"/> No <input type="checkbox"/> Yes What kind? _____
	Do you drink 4 large glasses of milk daily or take Calcium supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No
Weight	Has your weight changed recently? <input type="checkbox"/> No <input type="checkbox"/> Yes # _____ of pounds over _____ mos/yrs:
Exercise	Do you exercise regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes What kind of exercise? _____
	How long? (minutes)? _____ How often? _____
	If you do not exercise, why? _____
11. Review of Body Systems (Check all that are applicable and explain if needed)	
Constitutional	<input type="checkbox"/> Chills <input type="checkbox"/> Excessive urination <input type="checkbox"/> Fever <input type="checkbox"/> Weight gain <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Fatigue <input type="checkbox"/> Night sweats <input type="checkbox"/> Weight loss
Eyes	<input type="checkbox"/> Recent changes in vision <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
HENT (Head, ears, nose and throat)	<input type="checkbox"/> Hay fever/allergies <input type="checkbox"/> Problems with teeth/gums <input type="checkbox"/> Sinus pain/congestion
Breasts	<input type="checkbox"/> Changes in skin <input type="checkbox"/> Discharge <input type="checkbox"/> Lumps <input type="checkbox"/> Pain
Cardiovascular	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations
Respiratory	<input type="checkbox"/> Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing
Gastrointestinal	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Blood in stools <input type="checkbox"/> Diarrhea
	<input type="checkbox"/> Bloating <input type="checkbox"/> Constipation <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting
Genitourinary/Gynecological	<input type="checkbox"/> Frequency <input type="checkbox"/> Incontinence <input type="checkbox"/> Sexual dysfunction <input type="checkbox"/> Urinary retention
	<input type="checkbox"/> Blood in urine <input type="checkbox"/> Pain with urination <input type="checkbox"/> Urgency <input type="checkbox"/> Vaginal discharge
Integument	<input type="checkbox"/> Changes to existing skin lesions or moles <input type="checkbox"/> Rash
Neurological	<input type="checkbox"/> Dizziness/lightheaded <input type="checkbox"/> Headaches <input type="checkbox"/> Convulsions <input type="checkbox"/> Numbness
Psychiatric	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty sleeping
Hematologic-Lymphatic	<input type="checkbox"/> Bleeding disorder <input type="checkbox"/> unexplained lumps <input type="checkbox"/> Blood clots
Musculoskeletal	<input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Back pain
Others not mentioned above	