Health ONE Rocky Mountain Gynecologic Oncology Physician Care℠

Health History Form

Name: _____ Date of Birth: _____ Age: _____
Reason for Your Visit Today: _____
Occupation: _____ Religion: _____

Do you smoke? Yes No If yes, how many packs per day? _____
Have you ever smoked? Yes No If yes, when did you quit? _____
Do you use alcohol? Yes No If yes, how many drinks per week? _____
Do you or have you used the following: Marijuana Cocaine Heroin Crack Methamphetamine

Are you experiencing of these symptoms today? Circle all that apply

Constitutional: Fatigue/ Fever/ Weight Gain or loss/ Dizziness/Fainting
ENT/Mouth: Blurred vision/Ear pain/Nasal or sinus drainage/Mouth ulcers
Cardiovascular: Palpitations/Chest Pain/Leg swelling
Respiratory: Cough/Wheezing/ Shortness of Breath
Gastrointestinal: Abdominal Pain/Nausea/Vomiting/Diarrhea/Constipation/Pelvic Pain
Genitourinary: Urgency/Frequency/Incontinence/Painful Urination/Blood in Urine
Abnormal Bleeding/Vaginal Discharge
Musculoskeletal: Back pain/Joint pain/ Use of walker/cane/wheel chair
Skin: Rash/Itching/Drainage from incision
Neurological: Balance problems/Weakness/Neuropathy
Psychiatric: Anxiety/Depression/Insomnia/Confusion
Hem/Lymph: Night sweats/Hot Flashes/Vaginal Dryness/ Decreased Libido

Have you had any flu like symptoms in the past 7 days? Yes or No
In the past 3 weeks have you traveled outside of the US? Yes or No
In the past 3 weeks have you been in close contact with someone who has traveled outside the US? Yes or No

Are you allergic to any medications? Yes or No (If yes, please list.) _____
_____

Current Medications	**Dosage**

Previous Surgery	Date

Gynecologic History: Could you be pregnant: Yes or No Birth Control Method_____
Date of Last Menstrual Period or year you went through Menopause: _____
Date of Last Pap smear: _____Results: _____
History of Abnormal Pap Smears: Yes or No If yes, type of abnormality: _____
Date of last Mammogram: _____Date of last Colonoscopy: _____
History of Sexually Transmitted Disease: Yes or No If yes, type: _____
Total Number of Pregnancies: _____ Number of Full Term Births: _____
Vaginal Deliveries: _____C-Sections: _____Miscarriages/Abortions: _____ Adopted: _____
Are you sexually active: Yes or No

Have you ever had any of the following: Circle all that apply

Asthma	Kidney Disease	Depression	Blood Clot/DVT/PE
Stomach Problems	Pacemaker	Anxiety	High Blood Pressure
Bladder Problems	Anemia	Diabetes	Thyroid Disease
Lung Problems	Stroke	Cancer	High Cholesterol
Alcoholism	Epilepsy/Seizures	Hepatitis	Heart Disease/Heart Attack
HIV/AIDS			

_____

Do any of these conditions run in your family? Circle all that apply:

Alcoholism Addiction Joint Disease Stroke Blood Clots Diabetes
Psychiatric Disorder Heart Disease Cancer Other: _____

Have you ever had any genetic testing? Yes or No If yes, what have you had and when?

_____

How did you hear about us? Circle all that apply

Website Family/Friend Internet Search

Former or Current Patient? (Please provide so we can thank them!) _____

Physician (please specify): _____

Other Healthcare Facility (please specify): _____

Insurance Network (please specify): _____

Other (please specify): _____