Date: ____________

PATIENT HISTORY FORM

Patient Name: ____ Date of Birth: ___________________________
Address: ____ City: ________________ State: _____ Zip code: _________
Primary Phone# (   ) ________________________ **Email Address:** ____
In an emergency, whom should we contact? Name: __________________________ Phone Number (____)_______________
In the event we need to verify your identity over the phone, please list a password only you would know: ____________________

YES ☐ NO ☐ ARE YOU CURRENTLY TAKING ANY MEDICATION? Please list:

Name	Dose	Frequency	Date Last Taken	Reason
______________________	_______	_________	___________	_____________________
______________________	_______	_________	___________	_____________________
______________________	_______	_________	___________	_____________________
______________________	_______	_________	___________	_____________________

MEDICAL HISTORY

YES ☐ NO ☐ **Allergies** (Medications, Food, Latex, Iodine, Etc.)
What:_____________________________
Type of Reaction:___________________________
YES ☐ NO ☐ **C-Sections**
Year(s): ____________________________
YES ☐ NO ☐ **Surgery of ANY Kind**
Type(s):____________________________
YES ☐ NO ☐ **Asthma**
Date of Last Attack? ____________________
YES ☐ NO ☐ **Cancer**
Type(s):____________________________
YES ☐ NO ☐ **Bleeding Disorders**
YES ☐ NO ☐ **Blood Transfusion**
Year(s):____________________________
YES ☐ NO ☐ **Seizures**
Date of Last Seizure:____________________
YES ☐ NO ☐ **Anesthesia Problems**
Type:______________________________
YES ☐ NO ☐ **If other medical conditions or serious injuries, explain:**____
YES ☐ NO ☐ **Have you received Rhogam for prior pregnancies?**

YES ☐ NO ☐ **High Blood Pressure**
YES ☐ NO ☐ **Heart Disease**
YES ☐ NO ☐ **Blood Clots in Veins**
YES ☐ NO ☐ **Diabetes**
YES ☐ NO ☐ **Liver Disease/ Hepatitis**
YES ☐ NO ☐ **Kidney/ Bladder Problems**
YES ☐ NO ☐ **Severe Depression**
YES ☐ NO ☐ **Sickle Cell Anemia**
YES ☐ NO ☐ **Anemia**
YES ☐ NO ☐ **Tuberculosis**
YES ☐ NO ☐ **Severe Headaches**
YES ☐ NO ☐ **Body/Facial Piercing (besides ears)**
YES ☐ NO ☐ **Thyroid Problems**
YES ☐ NO ☐ **Malignant Hyperthermia**
YES ☐ NO ☐ **Are you currently Breastfeeding?**
YES ☐ NO ☐ **Have you had a tubal sterilization?**
YES ☐ NO ☐ **Are you done having children?**

YES ☐ NO ☐ History of an abnormal pap?
Treatment:______________________________
YES ☐ NO ☐ History of an STI?
Treatment:______________________________
YES ☐ NO ☐ Have you had a new sexual partner since your last STI screen?
YES ☐ NO ☐ Have you had unprotected intercourse in the last 72 hours?

Date of last Pap:_______________ Result:_________
Date of last STI screen:____________ Result: _________
Date of last Breast exam: ____________

SOCIAL HISTORY

YES ☐ NO ☐ Do you use recreational drugs?
What: ________________ Last used: ______________
YES ☐ NO ☐ Have you consumed alcohol in the past 24 hours?
What: ______________ Amount: _________When_______
YES ☐ NO ☐ Have you smoked tobacco in the past 90 days?
What: ________________ Amount per day: ___________

FAMILY HISTORY

YES ☐ NO ☐ Do you have family history of diseases?
Explain:

PREGNANCY HISTORY

Total pregnancies (including current): _______ Abortions: _______ Miscarriages: _______ Stillbirths: _______ Number of live births: _______

Ectopic pregnancies: _________ Ruptured? YES ☐ NO ☐ **BIRTH CONTROL REQUESTED:** ________________________________

Problems with pregnancies and / or abortions: ____

**************************************THE FOLLOWING FOR OFFICE USE ONLY***

HEALTH HISTORY REVIEWED / REVISED WITH PATIENT:

MLP / MD Signature: ____ Date: ____________________

MLP / MD Signature: ____ Date: ____________________

1.200 Reviewed by Emp#: ___

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