Joan G. Lovering Health Center of Portsmouth
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Name: _____ Date:_____

HEALTH HISTORY

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Medications currently taking (prescription, over the counter, vitamins, herbs, etc.) _____
_____
Allergies _____
Ever been hospitalized? **Y / N**
For what reason?_____

MEDICAL HISTORY *(Check any that pertain to you)*

Abdominal Pain _____
Anemia _____
Anxiety _____
Asthma/Hay fever _____
Back Pain _____
Bleeding disorder _____
Blood Clots _____
Blood in stool _____
Blood Transfusions _____
Breast surgery _____
Cancer _____
Chest Pain _____
Colposcopy, Cervical Biopsy, Cryosurgery, LEEP, Conization_____
Constipation _____
Diabetes _____
D & C _____
Diarrhea _____
Dizziness _____
Ear/nose/throat problems _____
Eating Disorder _____
Endometriosis _____
Eye problems _____
Fatigue _____
Gallbladder problems _____
Gyn surgery ____
Headaches _____
Heartburn _____
Heart Murmur ____
Heart problems _____
Hepatitis A,B,C _____
Herpes_____
High Blood pressure _____
HIV _____
Kidney problems _____
Mouth/gum/teeth problems _____
Nausea _____
Ovarian cysts _____
Pelvic infection/ PID _____
Pneumonia _____
Psychiatric care _____
Recent weight gain/loss _____
Shortness of breath _____
Seizures _____
Skin problems _____
Sexually transmitted disease _____
TB ____
Thyroid problems _____
Ulcers _____
Urinary tract infections _____
Vaginal infections _____
Varicose veins _____
Other _____

Have you had the following illnesses or immunizations? *(check all that apply)*
Measles _____ Rubella _____ Mumps _____ Chicken pox _____ Hepatitis A _____ Hepatitis B _____

FAMILY MEDICAL HISTORY

Heart problems _____ Stroke _____ High blood pressure _____ Diabetes _____ Cancer _____
Blood problems _____ Osteoporosis _____ Glaucoma _____ Thyroid problems _____ Alcoholism _____

SOCIAL HISTORY

If you feel it is important for us to know, please indicate if you consider yourself:
Heterosexual _____ Homosexual _____ Lesbian _____ Bisexual _____ Transgender _____ Lesbian _____
Celibate _____ Queer/questioning _____Other _____
Gender Identity____ Biological sex____Which pronoun do you prefer? She___ He___ They ___ Other_____
Do you smoke? **Y / N** How many each day? ____ Smoked how many years? _____
Do you drink alcohol? **Y / N** How much? _____ How often? _____
How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?
_____
Do you drink/take caffeine ? **Y / N** How much? _____ How often? _____
Do you exercise? **Y / N** How often? _____
How do you describe your eating habits? _____
Are you happy with your weight? **Y / N**

How many hours of sleep do you generally have each night? _____
Do you have problems falling asleep or staying asleep? **Y / N**
During the past month, have you often been bothered by feeling down, depressed or hopeless? **Y / N**
During the past month, have you often been bothered by little interest or pleasure in doing things? **Y / N**

Because violence is so common, we ask all our patients these questions:
Are you currently or have you ever experienced emotional abuse, domestic violence, or sexual assault? **Y / N**
Within in the past year, have you been hit, slapped, kicked or otherwise physically hurt by someone? **Y / N**
Are you in a relationship with a person who threatens or physically hurts you? **Y / N**
Has anyone forced you to have sexual activities that made you feel uncomfortable? **Y / N**

Do you always wear seatbelts? **Y / N** Do you always wear a helmet on a bike or motorcycle? **Y / N**
Dietary restrictions _____
Stresses: (family, work, self, etc.) _____
Do you have a primary care provider? **Y / N**

BIRTH CONTROL
Are you currently using birth control? **Y / N** If so, what kind? _____
Have you used other methods in the past? **Y / N** If so, what kind? _____
Any problems with methods used? **Y / N** If so, what kind? _____
Do you want to discuss birth control today? **Y / N**

FOR WOMEN PATIENTS ONLY

MENSTRUAL HISTORY
Age at first menses _____ Are your menses regular? **Y / N**
How many days does your menses last? _____ Flow: Light, Moderate, Heavy? _____
Do you have any of the following?
- Pain or cramps with your menses? **Y / N**
- Bleeding between your periods? **Y / N**
- Premenstrual symptoms? **Y / N**
- Pain or bleeding with intercourse? (If heterosexually active) **Y / N**

Do you douche? **Y / N**
Have you experienced menopause? **Y / N**
- If so, when was your last menses? _____
- Have you had any bleeding since your menses stopped? **Y / N**
- Do you have any hot flashes? **Y / N** Vaginal dryness? **Y / N**
- Do you take hormones? **Y / N**

PREGNANCY HISTORY Number of times pregnant: _____
Vaginal birth _____ Caesarian _____ Miscarriage _____Abortion_____
Still Birth _____ Ectopic _____ Premature delivery _____
Any pregnancy related complications? **Y / N**
Are you currently sexually active? **Y / N**
Are you planning to become pregnant in the next 12 months? **Y / N**
Problems/concerns with infertility?_____

GYNECOLOGICAL HISTORY
Date of most recent pelvic exam _____ Pap smear _____ Abnormal pap smears? _____
Are you experiencing any breast problems? **Y / N**
Breast Lumps? **Y / N** Breast pain? **Y / N**
Nipple Discharge? **Y / N**
Do you leak urine when you cough, laugh, lift something or sneeze? **Y / N** How often? _____
Do you ever experience a strong urge to urinate if not making it to the bathroom on time? **Y / N**