**Patient History Form**

Guiding Star Project

|  |  |  |
| --- | --- | --- |
| **Patient Name:**  |  **Age:** | **Date of Birth:**  |
| **Allergies:** |  |  |
| Medication or Item (i.e. latex) | Reaction (What Happened) | When: |
|  |  |  |
|  |  |  |
|  |  |  |

**Past Medical History (your personal history)** Please check all that apply; for items with more than one option, please circle the appropriate selection:

|  |  |  |
| --- | --- | --- |
| * Diabetes
 | * Blood Transfusion
 | * Reproductive Treatment
 |
| * High Blood Pressure
 | * Rh Sensitivity
 | * Measles/Chicken Pox
 |
| * Autoimmune Disorder
 | * Pulmonary (TB/asthma)
 | * Anemia
 |
| * Kidney Disease/UTI
 | * Seasonal allergies
 | * Bone/Joint disease
 |
| * Neurologic/Epilepsy
 | * Breast Disease
 | * Bowel Disease
 |
| * Psychiatric/Anxiety
 | * Gynecological Surgeries
 | * Lung Disease
 |
| * Depression/Postpartum Dep
 | * Hospitalization/Operations
 | * Stomach ulcer/acid reflux
 |
| * Hepatitis/Liver Disease
 | * Anesthesia Complications
 | * Migraines
 |
| * Varicosities/Blood Clots
 | * History of abnormal pap
 | * Stroke
 |
| * Thyroid Disease
 | * Uterine anomaly
 | * Cancer
 |
| * Trauma/Violence
 | * Infertility
 | * Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  |  |  |
| **Surgical History/Hospitalizations:** |  |  |
| Procedure/Hospital Admission | Reason |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Pregnancy History:** (Includes all pregnancies)

|  |  |  |
| --- | --- | --- |
| Number of pregnancies:  | Miscarriages: | Abortions: |
| Ectopic Pregnancies: | Live Births:  |  |

**Past Pregnancies (**to be completed by all patients who have ever been pregnant and have not yet reached menopause)**:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| DeliveryDate | Wks pregnant | Length of labor | Birth Weight | Gender | Vaginal/ Cesarean | Anesthesia? | Complications: | Name |
|  |  |  |  |  |  |  |  |  |
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**Medications** (please list ALL medications you are currently taking) **:**

|  |  |  |
| --- | --- | --- |
| **Name** | **Dose** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Gynecological History** (please check all that apply):

|  |  |  |
| --- | --- | --- |
| * Abnormal Pap Smear
 | If yes, when:\_\_\_\_\_\_\_\_\_\_ |  |
| * Sexually Transmitted Infection
 | Which one(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Treated (Y/N):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Contraception
 | If yes, which type(s):\_\_\_\_\_\_\_\_\_\_\_\_ | How Long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * PMS
* Abnormal Bleeding
 |  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 General Questions:

 Date of last pap smear:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last mammogram:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Age at first period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of sexual partners in lifetime:\_\_\_\_\_\_\_\_\_\_

**Social History:**

Marital Status:  Single  Married  Divorced  Widowed  Partner

 Name of Spouse (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_

 Children’s names (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Your Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Check all that apply:

|  |  |  |
| --- | --- | --- |
| * Current smoker
 | If yes, how much:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| * Drink Alcohol
 | If yes, what type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | How often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Drink Caffeine
 | If yes, what type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | How often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Use IV drugs
 | If yes, what type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | How often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Use Marijuana
 | If yes, how often:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Last used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * History of Domestic Abuse
 | If yes, when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Currently safe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * History of Sexual Abuse
 | If yes, when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

**Family History** (please check all that apply and indicate which family member/side of family):

|  |  |  |
| --- | --- | --- |
| * Breast Cancer
 | Who:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age:\_\_\_\_\_\_\_ |
| * Ovarian Cancer
 | Who:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age:\_\_\_\_\_\_\_ |
| * Colon Cancer
 | Who:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age:\_\_\_\_\_\_\_ |
| * Endometrial Cancer
 | Who:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age:\_\_\_\_\_\_\_ |
| * Diabetes
 | Who:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age:\_\_\_\_\_\_\_ |
| * High Blood Pressure
 | Who:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age:\_\_\_\_\_\_\_ |
| * Heart Disease
 | Who:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age:\_\_\_\_\_\_\_ |
| * Stroke
 | Who:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age:\_\_\_\_\_\_\_ |
| * Thyroid Disease
 | Who:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age:\_\_\_\_\_\_\_ |
| * Osteoporosis
 | Who:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Age:\_\_\_\_\_\_\_ |

*If you are currently pregnant, please complete the following section:*

**Genetic History and Infection History** (Includes you, baby’s father, and family members on both sides):

Please check all that apply and note which family member in the comments below:

|  |  |  |
| --- | --- | --- |
| * Thalassemia
 | * Maternal Metabolic Disorders
 | * Muscular Dystrophy
 |
| * Neural tube defect
 | (Type I DM, PKU) | * Cystic Fibrosis
 |
| * Congenital Heart Defect
 | * Birth Defects (i.e. cleft lip)
 | * Exposure to TB
 |
| * Down Syndrome
 | * Recurrent loss/stillbirth
 | * Genital herpes (you/partner)
 |
| * Tay Sachs
 | * Canavan Disease
 | * Hepatitis B or C (you)
 |
| * Huntington’s Chorea
 | * Familial Dysautonomia
 | * Gonorrhea/Chlamydia (you)
 |
| * Mental Retardation/Autism
 | * Sickle cell disease or trait
 | * HIV (you)
 |
| * Chromosomal Disorders
 | * Hemophilia/bleeding disorder
 | * Syphilis (you)
 |

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