**Patient History Form**

Guiding Star Project

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

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Delivery  Date | 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) **:**

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| --- | --- | --- |
| **Name** | **Dose** | **Frequency** |
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**Gynecological History** (please check all that apply):

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| --- | --- | --- |
| * 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_