

CONFIDENTIAL PERSONAL HEALTH INVENTORY

This CONFIDENTIAL report will become part of your medical record.

Please answer each question.

Fill in the blank with the appropriate information or a checkmark.

Name: _____ Date of Birth: _____

MENSTRUAL HISTORY

Age at onset of menstruation: _____

Periods have been: Regular ___ Irregular ___ or Very Irregular ___

Amount of menstrual flow: Scant ___ Moderate ___ Severe ___

Are periods painful? No ___ Mild ___ Moderate ___ Severe ___

First Day of Last Period: _____ Was it normal? _____

Previous period started on: _____

Last Pap Smear: _____

History of abnormal Pap smears? _____

HISTORIES OF PREVIOUS PREGNANCIES

How many times have you been pregnant? _____

Number of living children: _____

Full-term babies: _____ Miscarriages: _____

Premature babies: _____ Elective abortions: _____

Complications at any delivery: _____

Have all your children been normal? _____

PAST SURGICAL AND MEDICAL HISTORY

List any surgical operations and dates: _____

List any childhood diseases you have had (German Measles, etc.): _____

List any serious illness requiring hospitalization: _____

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List any serious illness not requiring hospitalization: _____

ALLERGY HISTORY

Have you had any allergic reaction to any medicine or injection? _____

If so, please explain: _____

Have you been told by a physician that you should not take a certain medicine? _____

If so, please explain _____

Do you smoke? YES _____ NO _____

SOCIAL HISTORY

Married _____ Husband's name: _____ Health: _____

Number of years married: _____

Single _____ Separated _____ Widowed _____ Divorced _____

Contraception used: Yes _____ No _____

Pills _____ Diaphragm _____ Rhythm _____ Condom _____

IUD _____ Withdrawal _____ Tubal ligation _____ Vasectomy _____

Other _____

IMMUNIZATIONS

	YES	NO	DATE
DPT			
Tetanus Booster			
Polio			
Measles			
German Meaeles (Rubella)			
Hepatitis B			
HPV (Gardasii)			

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	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
EYES			EARS		
Glasses or contacts	_____	_____	Any loss of hearing	_____	_____
Double vision	_____	_____	Ringing in ears	_____	_____
Pain in eyes	_____	_____	Drainage from ears	_____	_____
 NOSE			 TEETH		
Frequent nosebleeds	_____	_____	Any sores in mouth	_____	_____
Loss of sense of smell	_____	_____	Denture work	_____	_____
			Last dental checkup	_____	_____
 THROAT			 BLADDER/KIDNEY		
Infections of throat	_____	_____	Pain/Burning on urination	_____	_____
Difficulty swallowing	_____	_____	Increased frequency		
Hoarseness	_____	_____	of urination	_____	_____
Heart and Lungs	_____	_____	Up at night to urinate	_____	_____
Pains in the chest	_____	_____	Incontinence, stress,		
Shortness of breath	_____	_____	or urgency	_____	_____
Irregular heartbeat	_____	_____			
Rapid heartbeat	_____	_____	 GASTROINTESTINAL		
Productive cough	_____	_____	Abdominal pain	_____	_____
Asthma	_____	_____	Nausea	_____	_____
Hay fever	_____	_____	Vomiting	_____	_____
Bronchitis	_____	_____	Weight gain	_____	_____
Pneumonia	_____	_____	Weight loss	_____	_____
Night sweats	_____	_____	Excessive gas	_____	_____
 SKIN			Any food you can't eat?	_____	_____
Psoriasis	_____	_____	List: _____		
Eczema	_____	_____	_____		
Medications for skin	_____	_____	_____		
disorders	_____	_____	_____		
	_____	_____	_____		

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	<u>YES</u>	<u>NO</u>
NEUROMUSCULAR		
Pain in muscles, bones or joints?	_____	_____
Any broken or fractured bones?	_____	_____
Any restriction or limitations of movement of any part of your body?	_____	_____
Any fainting or spells of consciousness?	_____	_____
How many: _____		
Loss of feeling or abnormal sensations of any part of your body?	_____	_____

FAMILY HISTORY

List any of the following: Cancer of the ovary, uterus, breast, colon, diabetes, Thyroid disorders, heart disease, blood clots, strokes, high blood pressure.

Family Member	State of Health	If Deceased. Age & Cause
Father	_____	_____
Mother	_____	_____
Brothers # _____	_____	_____
Sisters # _____	_____	_____

ADDITIONAL INFORMATION

Do you have any additional information that you feel would assist us in providing better medical care for you? Please explain below. Thank you.

Patient Signature: _____ Date: _____