LINTECUM AND NICKELL, P.C.
MEDICAL HISTORY FORMS
HEALTH HISTORY

Pt # _____
Dr # _____

PATIENT NAME _____ DOB ___/___/___ AGE _____

PREFERRED/NICK NAME _____ PREVIOUS LAST NAME/MAIDEN NAME _____

E-MAIL: _____

TO HELP US MEET ALL YOUR HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.

Reason for visit (please be specific) _____

VISIT DATE _____ When was your: Last physical exam? _____ Last pap? _____ Last mammogram? _____

1. **PAST MEDICAL HISTORY** & other hospitalizations – Have you ever had the following: **__No medical history to report**

	Date		Date		Date
__Abnormal Mammo		__Gall Bladder		__Osteoporosis	
__Acid Reflux		__GI Disorder		__Skin Cancer	
__Anemia		__Heart Disease		__Stroke	
__Anxiety Disorder		__High Blood Pressure		__Thyroid-overactive	
__Arthritis		__High Cholesterol		__Thyroid-under active	
__Bleeding Disorder		__Joint Disorder		__Trauma	
__Blood in Urine		__Kidney Disorder		__Urinary Incontinence	
__Cancer		__Kidney Stones		__Urinary Tract Infection	
__Convulsions		__Liver Disorder		__any other disease (please specify)	
__Depression		__Lupus			
__Diabetes		__Osteopenia			

Please list the name of your primary care physician and any other specialists you are currently seeing: _____

2. **PAST SURGICAL HISTORY** – Have you ever had the following: **__I have had no surgeries**
Please list all operations you have experienced and indicate year these occurred

☐ Abdominal		☐ Hysterectomy		☐ Splenectomy	
☐ Breast		☐ Knee/Foot		☐ Tonsillectomy	
☐ Colonoscopy		☐ Laparoscopy		☐ Other Surgeries	
☐ EGD		☐ Lumbar Disc		☐ Other Surgeries	

3. **MEDICATIONS:** Please list all **medicines** you are currently taking **__I take no Medications**
(please continue on separate sheet)

CURRENT MEDICATIONS:	DOSAGE (mg)	How often per day?

4. Please list all **ALLERGIES** (food, drugs, and environment) **__I have no Allergies**

5. **FAMILY HISTORY**: Has any blood relative had any of the following: (Check box, leave blank if uncertain)

I have no family history of **__Breast Cancer** **__ Colon Cancer** **__ GYN Cancer**

	Relationship		
☐ Heart Disease		☐ Stroke	
☐ High Blood Pressure		☐ Genetic Problem	
☐ Kidney Problem		☐ Mental Health	
☐ Bleeding Disorder		Type	
☐ Cancer		Type	
☐ Diabetes		Type	

Pt # _____

Dr # _____

6. **GYN / MENSTRAL / SEXUAL HISTORY:**

Age of 1st period _____ Do you have a period every month? Yes/No 1st day of last period _____

Days between period #_____ Total # days on period _____ Flow: Light Medium Heavy

How many days are heavy?_____ How many tampons/pads used on the heaviest day?_____

Spotting in between periods?_____ Method of Birth Control _____

Do you have… Headaches? Yes/No Cramps? Yes/No PMS? Yes/No Before or During period? (please circle)

Menopause Status: Pre / Peri / Post Age at Menopause _____

Have you ever had an abnormal Pap test? Yes/No Evaluation/treatment_____

Have you received HPV vaccine? Yes/No

Age of 1st intercourse _____ Have you had more than five (5) sexual partners in your lifetime? Yes/No

Have you had a bone density (patients over 50)? Yes/No

7. **PREGNANCY:**

Total pregnancy #_____ Full Term # _____ Premature #_____

Terminated # _____ Miscarriages # _____ Ectopic # _____

Multiple # _____ Living # _____

Pregnancy details: ☐ please continue on separate sheet

Date	Birth Wt	Sex	Type of delivery	Complications	Location

8. **SOCIAL HISTORY:**

Tobacco: ☐ never ☐ minimal ☐ yes (___packs/day x ___ yrs) ☐ quit ___yrs ago (___packs/day x ___ yrs)

Alcohol: ☐ never ☐ minimal ☐ less than 10 per week ☐ more than 10 per week

How much/how often do you exercise?_____

Illicit drug: ☐ No ☐ Yes what type: _____

Nutrition: Are you… Vegetarian? Yes/No Vegan? Yes/No Gluten Sensitive? Yes/No

How many servings (1/2 cup = 1 serving) of fruits/vegetables do you consume on a typical day? _____

Marital Status: ☐ single ☐ married ☐ widowed ☐ divorced ☐ partner

Occupation: _____

LINTECUM AND NICKELL P.C.
OBSTETRICS AND GYNECOLOGY

Pt # _____
Dr # _____

Reason for visit (Please choose one):

____Annual Well-Woman Exam

-Please Note: **Insurance will not allow us to address significant problems (such as pain) at this visit.**

____Repeat Pap

____Routine Follow-up

-Your doctor asked you to schedule a visit to check on medications or a stable condition.

____Pessary Insertion/Check

____Pre-operative or Post-operative visit

-You have surgery scheduled –or– have recently had a surgery and are here for scheduled follow-up.

____Postpartum Exam

-You had a baby about 6 weeks ago and are here for scheduled follow-up. (Also mark IUD placement if relevant.)

____Procedure

-Such as any Biopsy, Colposcopy, LEEP, Hysteroscopy, IUD placement, Pessary Fitting/Insertion , or Polyp Removal, that you are doing today.

____Problem Visit

-Any other visit. Please fill out the next section in as much detail as possible.

____Pregnancy

____Talk

Please list anything you would like to discuss with your doctor:

-If you did not schedule this as a problem visit, we may need to schedule another visit to address significant issues, but please list them anyway. PLEASE be as detailed as possible.

_____
_____
_____
_____

I have not had any significant problems or new symptoms in the past year _____ ☐

OR I have had significant problems in the past year with:

General (e.g., fatigue, fever, night sweats): _____ ☐
Eyes (e.g., vision problems): _____ ☐
ENT (e.g., headaches, sinus congestion): _____ ☐
Breasts (e.g, lumps, tenderness, nipple discharge): _____ ☐
Heart (e.g., chest pain, palpitations): _____ ☐
Lungs (e.g., shortness of breath, cough, wheezing): _____ ☐
GI (e.g, nausea, diarrhea/constipation, loss of appetite): _____ ☐
Urinary: (e.g, urgency, blood in urine, incontinence): _____ ☐
Skin (e.g, rash, changes to moles, itching): _____ ☐
Neurological (e.g, speech difficulties, seizures): _____ ☐
Musculoskeletal (e.g, joint or muscle pain): _____ ☐
Endocrine (e.g, weight changes, hair loss, excessive urination or thirst): _____ ☐
Psychiatric (e.g, anxiety, depression, difficulty sleeping): _____ ☐
Heme/Lymph (e.g, easy bleeding/bruising, tender or enlarged lymph nodes): _____ ☐
Allergy/Immune (e.g, allergy symptoms, frequent illness): _____ ☐

Name: _____ DOB: _____

Patient Signature: _____ Date: _____