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			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: _____

Name: _____ DOB: _____ Chart#: _____

Primary Care Physician (or nurse practitioner or PA): _____

Do you have periods? _____ First day of your last period/or reason you don't have periods:_____

Medications (or provide list):_____

_____

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 a Biopsy, Colposcopy, LEEP, Hysteroscopy, IUD placement, Pessary Fitting/Insertion, Polyp, or Removal

_____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.

_____

_____

_____

Nurse Notes:_____

_____

Please detail any significant problems you have had in the past year with: **None** ☐

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):_____ ☐

Patient Signature: _____ Date: _____