Dr. Pat Robinson

PATIENT HISTORY FORM

Name: _____ Age: _____ **Date**: ____/____/____

Reason for your visit today: _____

Circle your current contraception:

None Tubal ligation IUD Mirena Nuva Ring Patch Depo Provera Diaphragm Vasectomy Condoms
Oral contraceptives If Oral contraceptives, which one? _____

Medication Allergies: Yes No If Yes, please list _____

List all prescription medications you are currently using _____

Non-prescription products you use on a regular basis _____

When was the first day of your last menstrual period? _____ Period occurs every _____ days & lasts _____ days.

Age of first period? _____ Intermenstrual bleeding? Yes No Heavy periods? Yes No

Were you exposed to DES before birth? Yes No Last Pap Smear ___/___/___ Ever had an abnormal PAP smear? Yes No

Do you drink alcohol? Yes How much? _____ No

Do you exercise regularly? Yes No

When was your last mammogram? ____/____/____

Do you use seat belts? Yes No

Have you had a bone density evaluation? Yes No

Do you use recreational drugs? Yes How often? _____ No

Do you smoke? Yes No If Yes, how many per day? _____

Do you have a history of Sexually Transmitted Disease? Yes No

Do you perform breast self-exams monthly? Yes No

Have you ever had a colonoscopy? Yes ____/____/____ No

Circle any of the following illnesses that you currently have or have ever had:

- Stroke
- Asthma
- Ulcers
- Diabetes
- Osteoporosis
- Tuberculosis
- Heart disease
- Kidney stones
- Bowel trouble
- Chronic anemia
- Eating Disorder
- High cholesterol
- Seizures/Epilepsy
- Depression/Anxiety
- High blood pressure
- Thyroid disorder
- Bleeding disorder
- Blood transfusion
- Anesthesia reactions
- Mitral valve prolapse
- Chronic lung condition
- Autoimmune disease (lupus)
- Blood clots in legs/lungs/heart
- Hepatitis/Liver disorder/Jaundice

Cancer Yes No If Yes, please explain?_____

Any other diseases? _____

Circle any of the following illnesses that have occurred in your family's history:

- Breast cancer
- Ovarian cancer
- Colon cancer
- Stroke
- Diabetes
- Osteoporosis
- Thyroid disorder
- High blood pressure
- Any other disease? _____
- Elevated cholesterol
- Coronary artery disease

Surgeries or hospitalizations: Yes No

Type of surgery or reason for hospitalization: _____

Date: ___/___/___ Doctor: _____ Hospital/Facility: _____

Type of surgery or reason for hospitalization: _____

Date: ___/___/___ Doctor: _____ Hospital/Facility: _____

Type of surgery or reason for hospitalization: _____

Date: ___/___/___ Doctor: _____ Hospital/Facility: _____

Pregnancy history (include abortions, miscarriages and stillbirths):

Delivery date | Baby weight | Weeks pregnant | Hours in labor | Normal or C-section | Complications | Location

_____

_____

_____

Patient signature _____ **Dr signature** _____ Date ___/___/___ Review: 1 year 2 year