Duluth Family Medicine Clinic

Patient Health History Form

Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Occupation, if employed: _____

Sex Assigned at Birth: □ Female □ Male □ Intersex Gender Pronouns:_____ Gender Identity:_____

Allergies:_____ Reactions:_____

Medications (including over-the-counter, birth control methods, herbs, supplements, and vitamins):

Medication: _____ Dosage: _____ Medication: _____ Dosage: _____

Medication: _____ Dosage: _____ Medication: _____ Dosage: _____

Medication: _____ Dosage: _____ Medication: _____ Dosage: _____

Personal Medical History

Check if you have had any of the following:
□ Anemia □ Hepatitis/Liver Disease □ Anxiety □ Arthritis □ Asthma □ Bipolar disorder □ Blood clots or disorders □ Breast lump □ Cancer □ Coronary artery disease (heart disease or heart attack) □ Depression □ Diabetes □ Eating disorder □ Elevated (high) cholesterol □ Gallbladder disease □ GERD (reflux/heartburn) □ Headache, migraines □ Hypertension (high blood pressure) □ Infection (UTI) □ Irritable bowel disease □ Osteoporosis □ Renal (kidney) disease □ Schizoaffective disorder □ Schizophrenia □ Seizure disorder □ Stroke □ Substance use disorder □ Thyroid disease □ Urinary tract/bladder
Other – please list:_____

Have you ever had surgery? □ Yes □ No *If yes, please explain*:_____

Have you ever been hospitalized? □ Yes □ No *If yes, please explain*: _____

Family Medical History *check here □ if you do not know any biological family medical history.*

Place an "X" for any relatives with the following:	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Blood Disease/Blood Clots								
Cancer								
Cardiovascular (heart) Disease								
Diabetes								
Genetic Disease								
Hypertension (high blood pressure)								
Mental Health Disorder								
Osteoporosis								
Stroke								
Substance Use Disorder								
Thyroid Disease								
OTHER								

General Health

Do you smoke or use tobacco: □ Yes □ No If yes, how much per day? _____ Are you interested in quitting? □ Yes □ No
Do you use e-cigarettes/vaping? □ Yes □ No Do you drink alcohol? □ Yes □ No If yes, how many drinks per week? _____
Do you use recreational/street drugs? □ Yes □ No If yes, how often per week? _____
Have you ever used needles to take drugs? □ Yes □ No If yes, do you share needles? □ Yes □ No
How often do you exercise? _____
Are you being, or have you been sexually or physically mistreated? □ Yes □ No Do you want to talk about it? □ Yes □ No
Did you receive the following immunizations/vaccines: Hepatitis B □ Yes □ No HPV (Gardasil) □ Yes □ No
Tdap (Tetanus/diphtheria/pertussis) □ Yes □ No Is there anything else you would like us to know about you or your health?
_____

Sexual Health and Family Planning

Do you or your partner(s) want to be pregnant? Now____ In the future____ Never____ Unsure____ Are you or your partner(s) currently using a method of birth control? □ Yes □ No If yes, what method? _____How long have you used this method? _____ Any problems with this method? _____
Check which methods of Birth Control you have ever used: □ Birth Control Pills □ The Patch □ Vaginal Ring (Nuva Ring)
□ Spermicide □ Depo (The Shot) □ Diaphragm □ Norplant □ Cervical cap □ Implanon/Nexplanon □ Fertility awareness □ IUD
□ Cycle Beads □ Tubal ligation □ Withdrawal (Pull-out) □ Condoms □ Vasectomy
Check any of the following you currently have, or have had in the past: *(answer all that apply to you)*
□ Chlamydia □ HIV □ Gonorrhea □ Herpes □ Genital Warts/HPV □ Hepatitis B or C □ Syphilis
□ Pelvic Inflammatory Disease (PID) □Trichomonas □ Other, please list: _____
Have you ever been sexually active? □ Yes □ No Are you currently sexually active? □ Yes □ No
What are the gender(s) of your sexual partner(s)? _____
How many people have you had sex with in the last 3 months_____ 12 months_____?
What types of sexual activities do you practice? □ Vaginal □ Oral □ Anal □ Touch with hands
What do you do to prevent sexually transmitted infections (STIs)? _____

Gynecological and Breast History

Have you ever had a Pap smear? □ Yes □ No When was your last Pap smear? _____
Have you ever had an abnormal Pap? □ Yes □ No If yes, please explain: _____

Menstrual Cycle

When did your last period start? _____Was it normal? _____Age periods started: _____
Periods come every_____ days and last_____ days Periods are usually: □ light □ moderate □ heavy □ crampy □ irregular
Any other concerns regarding your menstrual cycle? _____

Pregnancy History

Are you pregnant now? □ Yes □ No □ Unsure Have you ever been pregnant? □ Yes □ No How many times? _____
# of live births _____date(s) _____ # of abortions _____ date(s)_____
# of miscarriages_____ date(s) _____ # of ectopic _____date(s)_____
Diabetes in pregnancy? □ Yes □ No Hypertension in pregnancy? □ Yes □ No
Any problems with pregnancy or birth? □ Yes □ No *If yes, please explain:* _____
_____

For Ages 40 and Over

Have you ever had a mammogram? □ Yes □ No Was it normal? □ Yes □ No If no, please explain: _____
Check if you have had any of the following: □ Hot flashes □ Trouble sleeping □ Night sweats □ Rapid mood changes
□ Vaginal dryness □ Libido problems □ Urine leaking □ Other: _____

The information on this Patient Health History Form is correct to the best of my knowledge.

Patient or Guardian Signature: _____Date:_____

Physician Signature: _____Date:_____