Associated Physicians, LLP
4410 Regent St
Madison WI 53705

CONFIDENTIAL HEALTH HISTORY

Name: ________________________________ DOB: _____________ Date: ______________
Age: ____________ Marital Status: ____________ Occupation: ________________________
Reason for visit: ____
Referring physician: ____
Name of Primary Care Provider: ____
Spouse/Partner's name: _______________________________ Occupation: ______________
List any other physicians or health care providers you see:
____

MEDICATIONS: List all prescription medications that you take (including birth control pills).

Medication Dose Frequency Date started Prescribing physician
____
____
____

List all non-prescription medications that you take regularly including vitamins, herbs and anti-inflammatory medications. (Including dose and frequency).
____
____

ALLERGIES:
List all Food, Drug ,Environmental allergies and type of reaction:________________________
____

HEALTH MAINTENANCE:
Date/Place of last:
Colonoscopy _______________ Bone Density _______________
Lipid Panel ________________ Blood sugar ________________
Vitamin D _________________
Date of last vaccines: **Tdap** _______ Flu _______ HPV _______ Shingles _______
Pneumonia _______ Meningococcal _______ Hepatitis B _______

MEDICAL HISTORY: Check if you have or have ever had and, if so, when

___ Alcohol abuse
___ Asthma
___ Blood clots
___ Diabetes
___ High cholesterol
___ Irritable bowel syndrome
___Seizure disorder
___Stomach ulcers
___Transfusion reaction
___ Anesthetic reaction
___ Anemia
___ Drug and substance abuse
___ Heart disease
___ Hepatitis/Jaundice
___ Kidney stones
___ Stroke
___ Mitral valve prolapse
____Eating disorder
___ Bleeding disorder
___ Chronic lung condition
___ Depression/anxiety
___ High blood pressure
___ Cancer
___ Hypothyroidism
___ Tuberculosis
___ Rheumatic fever
___ Lupus/autoimmune disorder

SURGICAL HISTORY: List all surgeries and/or invasive procedures you have had, including the type of surgery, year or age and comments:

____

____

SOCIAL HISTORY: Please check appropriate answer.

Marital Status: Married ____ Divorced: ____ Domestic partner: ____ Remarried: ____
Single: ____ Widowed: ____

Sexual Activity: Are you sexually active? Yes ____ No ____ Not currently ____

Current sexual partner(s) is/are Male ____ Female ____

Have you had more than 4 sexual partners in your lifetime? Yes ____ No ____

Have you ever had any sexually transmitted diseases (STDs)? Yes ____ No ____

Alcohol use: Yes ____ No ____ If yes, number of drinks per week? ____

Is your alcohol consumption a concern for you or others? Yes ____ No ____

Tobacco use: Cigarettes? Never ____ Quit, date ____ Current smoker, packs per day ________

Number of years ____ Other tobacco ______ Are you interested in quitting smoking? ________

Safety: Do you use seatbelts consistently? Yes ____ No ____

Do you wear a bike or motorcycle helmet? Yes ____ No ____

Is violence at home a concern for you? Yes ____ No ____

Have you experienced abuse in your past? Yes____No____

Do you have smoke and carbon monoxide detectors in your home? Yes ____ No ____

GYNECOLOGIC HISTORY:

When was the first day of your **last menstrual period**? ____________

Date of last **pap** smear: ______________________________________

Date/place of last mammogram: ______________________________

Are you currently pregnant? Yes ____ No ____ Maybe ____

Are you currently attempting pregnancy? ______ If so, for how long? _________

Contraception: Birth control pills ______ IUD ______ Condoms ______ Tubal ligation _____
Vasectomy _____ Other ______ Nothing and if so, reason _______

Do you perform monthly self breast examinations? Yes ____ No ____

GYNECOLOGIC CONDITIONS: Check if you have now or have had in the past, any of the conditions listed below:

_____ Pelvic pain
_____ Irregular menstrual period
_____ Bleeding between periods
_____ Postmenopausal bleeding
_____ PMS
Abnormal Pap smear:
    _____ LEEP procedure
    _____ Laser/freezing of cervix
    _____ Cone biopsy
_____ Pelvic prolapse
_____ Chronic vaginal yeast infections
_____ Chronic bacterial vaginosis
_____ Chlamydia
_____ Gonorrhea

_____ Lack of menstrual period
_____ Heavy menstrual flow
_____ Bleeding or pain after sexual activity
_____ Painful menstrual cramps
_____ Endometrial polyps
_____ Cervical polyps
_____ Ovarian cysts
_____ Endometriosis
_____ Polycystic ovarian syndrome
_____ Difficult menopausal symptoms
    ____ Hot flashes
    ____ Sleep disturbance
    ____ Vaginal dryness
_____ Herpes

Other sexually transmitted infections; ____

INFERTILITY HISTORY: (Complete if indicated) None ____________
How long have you been trying unsuccessfully to become pregnant? _________________________
Please describe any tests/diagnosis/treatments you have had performed ________________________
____
____

UROLOGIC HISTORY : (Complete if indicated) None ______________

Do you unintentionally leak urine	Yes ____ No ____
Does your incontinence occur after coughing, exercising, sneezing, or lifting?	Yes ____ No ____
Do you have a strong sense to urinate before losing your urine?	Yes ____ No ____
Do you wear a pad to protect against urine loss?	Yes ____ No ____
Do you use a pessary?	Yes ____ No ____

PREGNANCY HISTORY:
No pregnancies _______
Number of times pregnant _____ Full term births _____ Premature births _____
Elective termination _____ Miscarriages _____ Ectopic pregnancies _____
Adopted children _____ Step children _____ Twins _____

Pregnancies lasting more than 20 weeks:

Date	Gestational age at delivery	Vaginal or C-Section	Sex and weight	Hospital/Doctor	Complications

FAMILY HISTORY: Adopted ________
Please indicate which paternal and/or maternal family member(s)

Breast cancer: _________________________	Asthma: ______________________________
Ovarian cancer: ________________________	Stroke: ______________________________
Colon cancer: _________________________	High cholesterol: ______________________
Other cancers: _________________________	Bleeding disorders: ____________________
Diabetes: ____________________________	Drug abuse: __________________________
Heart disease: _________________________	Drinking problem: ______________________
High Blood Pressure: ___________________	Anesthesia Problems ___________________

PROVIDER COMMENTS: ____
____
____

Patient Signature: ____Date:______________