Athena Health and Wellness

MEDICAL HISTORY FORM

Today's Date: _____ Your Full Name:_____

Date of Birth: _____ Age: _____ When was your last period?_____

State the reason for your visit:_____

Medications: Please list any prescribed medications and over-the-counter vitamins/supplements/herbs you take:

_____

_____

Have you taken any antibiotics in the past month? □ Yes □ No

Allergies: Please check allergies that you have experienced in the past.

Medications □ Yes □ No If yes, please list drug AND reaction _____

X-ray dye or contrast □ Yes □ No Latex allergy □ Yes □ No Food allergy □ Yes □ No

Family History: Please check illnesses that have occurred in any of your **blood** relatives.

□ Heart Disease □ High Blood Pressure □ Diabetes □ Thyroid Problems

□ Mental Illness □ Cancer □ Breast / Ovarian Cancer in Female Members

Father: Living □ Yes □ No Cause of death or significant health problems _____

Mother: Living □ Yes □ No Cause of death or significant health problems _____

Did your mother use DES while pregnant with you? □ Yes □ No

Personal Medical History: Please check illnesses or conditions which you have had.

□ Heart Disease	□ High Blood Pressure	□ Diabetes	□ Thyroid Problems
□ Liver Disease	□ High cholesterol	□ Stroke	□ Cancer _____
□ Gallbladder Disease	□ Anemia or Blood Disorder	□ STDs_____	□ Blood clot in arm/legs/lung
□ Abnormal Mammogram	□ Breast disease/problems	□ Abnormal pap smear	□ Ovary/Uterus problems
□ Migraine headaches	□ Intestinal/stomach problems	□ HIV or AIDS	□ Asthma
□ Kidney/bladder problems	□ Seizures	□ Major depression	□ Psychiatric problems

□ Other medical problems including genetic:_____

Previous Surgeries: Please list surgery and year _____

_____

_____

Imaging/Tests: Have you had a mammogram? □ Yes □ No If yes, when_____

Have you had a colonoscopy? □ Yes □ No If yes, when_____

Have you had a bone density scan? □ Yes □ No If yes, when_____

Have you had a pap smear? □ Yes □ No If yes, when_____

Vaccines:

Have you had your MMR vaccine? □ Yes □ No

Have you had the Gardasil vaccine? □ Yes □ No

Social History:

Tobacco: □ None □ Now: Packs per day_____ □ Ex-smoker: Quit date_____

Alcohol: □ None □ Social □ Weekly □ Daily

Illegal drug use: □ Yes □ No

Do you feel safe in your current relationship? □ Yes □ No □NA

Do you feel safe in your current living situation? □ Yes □ No

GYNECOLOGICAL/SEXUAL HEALTH:

Age periods began_____
Do you have a period every month? Y N
Do you bleed between periods? Y N
Is your flow? Light Medium Heavy
How old were you when you first had sex? _____
Are your partners? Male Female Both
What methods of birth control have you used?

_____

What birth control method are you using now?_____
Are you have any problems with this method? Y N
Do you need a birth control method today? Y N
Any sex without birth control since your last period? Y N
Do you think you could be pregnant now? Y N
Do you use condoms? ☐ Never ☐ Occas ☐ Always ☐ NA

How may partners in the past? 2mos___ Year___ Life___
Have you had a new partner in the past 2 months? Y N
Does your partner have other partners? Y N
Date you last had sex_____

OBSTETRICAL:

How many times have you been pregnant? _____
Number of live births_____
Number of still births_____
Miscarriages_____
Abortions_____
C-sections_____
Tubal pregnancies_____
Any complications with any of your pregnancies? Y N
Did you have diabetes with any of your pregnancies? Y N

Review of Systems

Do you now or have you recently (in the past 6 months) had any problems related to the following systems? Please circle "Y" for Yes and "N" for No.

CONSTITUTIONAL

Fever Y N
Chills Y N
Weight Gain Y N
Weight Loss Y N
Height Loss Y N
Hot flashes Y N
Night sweats Y N
Fatigue Y N
Other _____

EYES

Blurred Vision Y N
Double Vision Y N
Other _____

EAR/NOSE/THROAT/MOUTH

Ear Infection Y N
Sore Throat Y N
Sinus Problems Y N
Other_____

BREASTS

Lumps Y N
Tenderness Y N
Swelling Y N
Nipple Discharge Y N
Breastfeeding Y N
Other:_____

CARDIOVASCULAR

Chest Pain Y N
Varicose Veins Y N
↑ Blood Pressure Y N
Other _____

RESPIRATORY

Wheezing Y N
Shortness Breath Y N
Chronic Cough Y N
Lung Conditions Y N
Other _____

GASTROINTESTINAL

Abdominal Pain Y N
Nausea / Vomiting Y N
Indigestion Y N
Heartburn Y N
Change in bowel habits? Y N
Other:_____

GENITOURINARY

Inability to Urinate Y N
Painful Urination Y N
Blood in Urine Y N
Urinary Frequency Y N
Urinary Leakage Y N
Urinary Urgency Y N
Urinating at Night Y N
Reoccurring UTIs Y N
Pelvic Pain Y N
Abnormal vag discharge Y N
Vaginal odor Y N
Vaginal irritation/itch Y N
Any pain with sex? Y N
Other_____

INTEGUMENTARY

Skin Rash Y N
Boils Y N
Persistent Itch Y N
Skin Discoloration Y N
Other _____

ENDOCRINE

Decreased Libido Y N
Other:_____

MUSCULOSKELETAL

Joint Pain Y N
Neck/Back Pain Y N
Other _____

PSYCHOLOGIC

Anxiety Y N
Depression Y N
Suicidal thought Y N
Other _____

HEMATOLOGIC

Swollen Glands Y N
Bruising Y N
Other _____

ALLERGIC/IMMUNOLOGIC

Seasonal Allergies Y N
Other _____

NEUROLOGICAL

Headaches Y N
Tremors Y N
Dizzy Spells Y N
Numbness Y N
Tingling Y N
Other _____

Patient Signature:

_____

NP Signature:_____
Date: _____