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| BMH Medical Group | **Brattleboro OB/GYN****Patient Health History Form** |
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| **Personal Information\*** |
| Last Name: |  | **First Name:** |  | **Middle Initial:** |  | **Gender:** |  |
| **Insurance Name & Gender (if different than above):** |
| **Photo ID Name & Gender (if different than above):** |
| **Birth Certificate Name & Gender (if different than above):****Date of Birth:** |
| Marital status:  | 🞎 Single 🞎 Partnered 🞎 Married 🞎 Separated 🞎 Divorced 🞎 Widowed 🞎Other |
| Pronouns | 🞎She/Her 🞎He/Him 🞎They/Them 🞎Other (Please list):  |
| **Other Members of Household (Relationships and Ages):** |
|  |
| **Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest Level of education completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Is English your primary language?** 🞎Yes 🞎No If no, what is\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| Provider HistoryPrimary Care Provider |
| Name:  |  | Address: |  |   |
|  |  |
| Current medical IssuesPlease briefly describe any medical issues or concerns that you are currently experiencing. |
| ***MEDICAL HISTORY****Mark the ‘C’ box for CURRENT conditions and ‘P’ for PAST conditions*

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| **C** | **P** | ***Cardiovascular*** | **C** | **P** | ***Cancer*** | **C** | **P** | ***Gyn/Urinary*** |
| **□** | **□** | High blood pressure | □ | □ | Cervical cancer | **□** | **□** | Endometriosis |
| **□** | **□** | High cholesterol | □ | □ | Ovarian cancer | **□** | **□** | Frequent UTI |
| **□** | **□** | Heart attack | □ | □ | Uterine cancer | **□** | **□** | Kidney stones |
| **□** | **□** | Blood clots | □ | □ | Colon cancer | **□** | **□** | Kidney infection |
| **□** | **□** | Heart murmur | □ | □ | Breast cancer | **□** | **□** | Blood inurine |
| **□** | **□** | Stroke | □ | □ | Lung cancer |  |  | ***Psychological*** |
| **□** | **□** | Clotting Disorder***Endocrine*** | □ | □ | Skin cancer | □ | □ | Depression |
| □ | □ | Chronic fatigue |  |  | ***Digestive/GI*** | □ | □ | Alcoholism/substance use disorder |
| □ | □ | Diabetes □ Type 1 □ Type 2 | □ | □ | Lactose intolerance | □ | □ | Eating disorder |
| □ | □ | Thyroid disorder | □ | □ | Stomach ulcer | □ | □ | Other mental illness |
| □ | □ | Polycystic Ovary Syndrome | □ | □ | Crohn’s Disease/colitis |  |  | ***Musculoskeletal*** |
|  |  | ***Neurological*** | □ | □ | Liver disease/Hepatitis | □ | □ | Arthritis |
| □ | □ | Epilepsy | □ | □ | Hemorrhoids | □ | □ | Osteoporosis |
| □ | □ | Seizures/convulsions | □ | □ | Diarrhea |  |  | ***Respiratory*** |
| □ | □ | Migraines | □ | □ | Constipation | □ | □ | Asthma |
| □ | □ | Frequent headaches | □ | □ | Gallbladder disease | □ | □ | Hay fever/allergies |

Other not listed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |
| Current Prescription Medications |
| **Medication Name** | **Dosage** | **Doses/day** | **Reason you take this medication** | **Refill Due Date** |
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 My signature acknowledges my understanding that the medical providers of BMH Medical Group are not obligated to prescribe any medications or any dosages of medications that they feel are not in my best interest.

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| **Signature** | **Date** |

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| Current Over the Counter Medications |
| **Medication Name** | **Dosage** | **Doses/ day** | **Reason you take this medication** |
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| Allergies  |
| **Allergen Name** | **What type of allergic reaction do you have?** |
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| Yes/no | Comments |
| PATIENT HEALTH SCREENINGSPlease indicate the date of your most recent screening and any outcomes or comments. |
| **Screening** | **Please check if complete** | **Outcome/Comment/Date of screening if you know** |
| General Physical |  |  |
| Dental |  |  |
| Mammogram |  |  |
| Colonoscopy |  |  |
| Pap Smear |  |  |
| Prostate Exam |  |  |
| Eye Exam |  |  |
| Vaccination |  |  |
|  |  |
| SUBSTANCE USE |
| Alcohol  | 🞎 Daily | 🞎 Weekly | 🞎 Monthly | 🞎 Yearly | 🞎 Never |
| Tobacco | 🞎 Daily | 🞎 Weekly | 🞎 Monthly | 🞎 Yearly | 🞎 Never |
| Recreational Drugs*Indicate which drug* | 🞎 Daily | 🞎 Weekly | 🞎 Monthly | 🞎 Yearly | 🞎 Never |
| Are you exposed to second hand smoke? | 🞎Yes | 🞎No  | 🞎 How Often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
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| FAMILY HEALTH HISTORYIn the space provided, please list any blood relatives who have had the following health conditions. |
| Cancer (type) |  | Heart Attack |  |
| Stroke |  | Heart Disease |  |
| Diabetes |  | High Blood Pressure |  |
| High Cholesterol |  | Mental/Behavioral  |  |
| Substance Use |  | Thyroid Disorder |  |
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| SURGICAL HISTORYPlease list all operation and hospitalization for reason other than childbirth |
| **DATE** | **HOSPITAL** |  **SURGERY/REASON FOR HOSPITALIZATION** |
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| **OBSTETRIC HISTORY**Please list ALL pregnancies in order, including pregnancy losses, terminations and perterm births |

Total number of pregnancies Number of births

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| --- | --- | --- | --- | --- | --- |
| DATE | HOSPITAL | WEEKS/DAYS | WEIGHT OF INFANT | SEX OF INFANT  | COMPLICATIONS |
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| **GYNECOLOGIC HISTORY**  |

Age of first period, if applicable Date of last menstrual period \_\_\_\_\_\_\_\_\_\_

Menses occur every days and last for days.

□ Not currently menstruating

Please specify why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (contraception, post-menopause, no uterus, etc.)

***Contraception: Check any that apply currently***

* None □ N/A; no male partner or not at risk for pregnancy
* Birth control pills □ Nexplanon □ Condoms □ IUD (which type?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Tubal ligation □ NuvaRing □ Depo-Provera □ Vasectomy

* Diaphragm □ Withdrawal □ Birth control patch □ Natural Family Planning

Other, not listed above: \_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in changing/starting a new contraceptive method? □ Yes □ No

***Pap Tests***

When was your last Pap test? Have you ever had an abnormal Pap? □ Yes □ No

Have you had the HPV vaccine (Gardasil)? □ Yes □ No □ Unsure

Have you ever had HPV? □ Yes □ No

## If you have a history of abnormal Pap:

Have you ever had a colposcopy? □ Yes □ No □ Unsure Date: Facility: Were biopsies taken? □ Yes □ No □ Unsure Date: Facility: Have you had any cervical procedures? □ Yes □ No □ Unsure Date: Facility:

***Have you ever been treated for:***

* Chlamydia
* Gonorrhea
* Trichomoniasis

□ Syphilis

* Pelvic Inflammatory Disease (PID)
* Recurrent Bacterial Vaginosis (BV)
* Recurrent Yeast infections
* HPV/gential warts
* HIV

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Do you currently have any of the following

## gynecologic problems or concerns?

□Heavy periods □ Spotting between periods □ Irregular periods

* Concerns about STDs/STIs
* Painful periods (requiring more than Tylenol, Advil)
* Vulvar odor or unusual discharge □ Vulvar itching, irritation, or lesions

□ Decreased libido □ Bleeding after intercourse □ Pain with intercourse

* Pelvic pressure □ Pelvic pain
* Loss of urine □ Menopausal symptoms
* History of sexual abuse If yes, have you talked with someone about this? □ Yes □ No
* Difficulty getting pregnant or need for assisted reproductive technology (insemination, etc.)

 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| REVIEW OF SYSTEMSPlease check all that currently apply |

**General/Constitutional**: □Fatigue □Fever □Chills □Unexplained weight loss □Unexplained weight gain

**Eyes:** □Wear Glasses or Contacts □Blurred Vision □ Floaters □Peripheral vision changes

**Head/Throat**: □Sore Throat □Sinus Pain/fullness □Hearing loss □Ringing in the Ears □ Migraine

□ Headache □Vertigo/dizziness □Lightheadedness

**Breast:** □Tenderness □Lumps □Skin Changes □Nipple pain □Nipple discharge

**Cardiovascular**: □Chest pain □Irregular heartbeats □Palpitations □Leg swelling

**Respiratory:** □Wheezing □Shortness of breath □Cough □Pain with breathing

**Gastrointestinal**: □Reflux/heartburn □Bloating □Diarrhea □Loss of appetite □Nausea

□Constipation □Vomiting

**Urinary:** □Leaking Urine □Urinary Frequency □Urinary Urgency □Painful Urination

□Blood in urine

**Gynecologic:** □Painful Intercourse □Painful periods □ Bleeding between periods

□Heavy periods □Frequent periods □Vaginal discharge □Hot flashes □Vaginal irritation/burning

□Genital lesions/ulcers □Decreased libido □Vaginal odor

**Skin:** □Rash □New skin lesion □Acne □Excessive hair growth

**Neurologic:** □Weakness of arms or legs □Tingling or numbness □Memory difficulties

**Musculoskeletal**: □Joint Pain □Hip pain □Back Pain □Knee Pain □Muscle Weakness

**Endocrine**: □Excessive thirst □Excessive urination □Loss of hair □Cold intolerance

□Heat intolerance

**Psychiatric: □**Marital Stress □Family Stress □Job Stress □Depression □Frequent Crying

* Excess anger/Irritability □Difficulty Sleeping □Anxiety □PTSD

**Hematologic/Lymphatic**: □Lymph node enlargement □Easy bruising □Easy bleeding

**Allergic/Immunologic**: □Sinus allergy □Allergic Dermatitis

##### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge that I have completed this form to the best of my ability. I realize that any information that I provide on this form will become part of my permanent medical record. I understand that any misrepresentations of my health history may result in an alteration of my current treatment plan, as deemed appropriate by my BMH Medical Group healthcare provider.

|  |  |
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| **Signature:** | **Date:** |
| **Name (print):** | **Relationship to Patient:** |
|  | **Power of Attorney 🞎 Yes 🞎 No** |

Form version 5/15/2019