JACKSON HEALTHCARE FOR WOMEN

Required Yearly History Form: 2019

TODAY'S DATE: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Reason for Visit: ☐ Wellness Exam ☐ Problem: _____

Date of Last Mammogram _____ Colonoscopy _____ Bone Density _____ Last Pap Smear _____

List Current Allergies to Any Medication: _____

List Current Medications: _____

_____

List Current Contraception: _____

Pharmacy/Mail Order: _____ Address: _____ Phone: _____

Menstrual Periods:

Date last period started? _____ How often are your periods? _____

How long do they last? _____ How heavy are they? _____

Surgeries (since last office visit): _____

_____

PERSONAL MEDICAL HISTORY

All other surgeries: _____

Obstetrics: Total # of Pregnancies _____ # of Living Children _____ # of Miscarriages _____

Illness: _____

Injuries/Accidents: _____

Your Tallest Height _____ ft. _____ in. Have you ever had a blood transfusion? Yes No Date: _____

Check if you have ever had: ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HIV ☐ Syphilis

Have you ever been tested for HIV? No Yes Date Tested: _____

FAMILY HISTORY

Mother: ☐ Living ☐ Deceased – Cause _____

Father: ☐ Living ☐ Deceased – Cause _____

Sibling(s): Number of Living _____ Number Deceased _____ Cause(s) of death: _____

Which of your parents, siblings, or children had the following: _____

Breast Cancer _____ Colon Cancer _____ Colon Polyps _____ Diabetes _____

Heart Disease _____ High Blood Pressure _____ High Cholesterol _____

Ovarian Cancer _____ Strokes _____ Osteoporosis _____ Other _____

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Number of people in household: _____

Smoking: Yes No Packs per day _____ Years _____ Alcohol: Yes No Drinks per day _____ Drinks per week _____

Illicit or Illegal Drug Use: Yes No Type: _____ Regular Exercise: Yes No

PLEASE TURN SHEET OVER AND COMPLETE OTHER SIDE

IMMUNIZATIONS

Circle any vaccines you have had and indicate the date last received on line provided.

Influenza (Flu)_____ Tdap (Tetanus, diphtheria, pertussis)_____ MMR (Measles, mumps, rubella)_____

Varicella (Chickenpox)_____ Zoster (Shingles)_____ HPV (Gardasil)_____

Pneumococcal (Pneumonia)_____ Meningococcal (Meningitis)_____ Hepatitis A_____

Hepatitis B_____ Other_____

Circle if you currently have any of the following:

CATEGORIES

Constitutional:	Fatigue	Weight Loss	Weight Gain
Eyes:	Glaucoma	Cataracts	Other_____
Cardiovascular:	High Blood Pressure	Shortness of Breath	Chest Pain
	Irregular Heart Beat	Swelling	Other_____
Respiratory:	Wheezing	Coughing up Blood	Asthma
	Cough	Shortness of Breath	Other_____
Breast:	Breast Pain	Nipple Discharge	Nipple Retraction
	Masses	Cancer	Other_____
Gastrointestinal:	Constipation	Diarrhea	Bloody Stool
	Pain in Abdomen	Nausea/Vomiting	Persistent Gas
	Other_____		
Genitourinary:	Hot Flashes	Blood in Urine	Urgency of Urination
	Cramps	Pain with Urination	Frequency of Urination
	Irregular Periods	Leakage of Urine	Abnormal Vaginal Bleeding
	Vaginal Odor	Vaginal Itching	Vaginal Skin Growths
	Painful Intercourse	Vaginal Discharge	Other_____
	Abnormal Pap Smear	Prior Treatment for Abnormal Pap Smear_____	
Neurological:	Migraines	Seizures	Numbness
Psychiatric:	Depression	Persistent Crying	Other_____
Endocrine:	Diabetes	Thyroid Disorder	Other_____
Lymph Nodes/Blood:	Swollen Glands	Anemia	Abnormal Bleeding from Skin
Skin:	Rash	Lumps	Lesions
Joints/Muscular:	Arthritis	Weakness	Other_____

Signature:_____