Dr. Montanarella and Associates: Health History Form

Name:		DOB:	Primary Care MD:
Occupation:			
Marital Status: Single, Married, Widow, Divorced, Separated, Living together			
Sexually Active: Yes No Partner: M F Both			
Age at first menses:	Age at last Menses/Menopause if applicable:		
Are your menses regular? Yes No Details:			
How often do you have your menses (example every 28 - 30 days):			
How long does your menses last (example: 5 - 7 days):			
How heavy is your flow? Light Moderate Heavy			

Lab Preference

______Elliot Lab ______Quest Diagnostic ______LabCorp ______Converge ______Other

Current Medications: Please List all current medications including vitamins and herbals

Medication Name:	Dosage:	Medication Name:	Dosage:

Allergies: List all Drug and Environmental allergies (INCLUDING LATEX) and reaction

Allergy:	Reaction:	Allergy:	Reaction:

Past Surgical History or Hospitalizations including colonoscopy, tubal ligations, other:

Surgery Type/ Hospitalization:	Date:	Surgery Type /Hospitalization:	Date:

Have you ever had difficulty with anesthesia: Yes, No If Yes, Please List Details:

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Obstetrical History

Please document all pregnancies including miscarriages and abortions. Please document gestational diabetes, hypertension, preeclampsia and other complications with pregnancy or birth.

	Hospital/ Delivering MD	Type: Vaginal, Cesarean, Miscarriage, Abortion	# of Weeks Pregnant at Delivery	Epidural, Spinal or labor medications	Infant Sex/weight	Infant Name	Length of labor	Preterm Labor? Yes/No
Date:								
Complications/Comments:								
Date:								
Complications/Comments:								
Date:								
Complications/Comments:								
Date:								
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Date:								
Complications/Comments:								

*****If more than 5 pregnancies please ask for additional obstetrical history page.*

Patient's Past Medical History: Please check Yes or No for any of the following current or past medical history. This is your personal history(not family history). Please indicate details where needed.

URO-GYN History:	Yes	No	Month/Year Diagnosed	Please list Details:
Abnormal Pap Smear				
Polycystic Ovarian (PCOS)				
Uterine Fibroids				
Endometrial Polyps or other Endometrial				
Ovarian Cysts				
Endometriosis				
Chlamydia, Gonorrhea, HPV or other STD				
Herpes				
Abnormal mammogram or breast problem				
Urinary Incontinence or other Urology				
Kidney Infection, Kidney stones				
Pelvic pain				
Vulvar disease: Lichen or other				
Infertility				
Pelvic inflammatory Disease				
Sexual Dysfunction				
Abnormal uterine shape				
Hormone therapy use (HRT)				
Have you ever had BRCA gene testing?				
Other GYN:				

Cancer History:

Have you had cancer of ANY TYPE (including skin)?				
Have you ever had Chemotherapy or Radiation therapy?				

Endocrine History:

Diabetes				
Insulin Resistance/PCOS				
Thyroid Disorder				
Other endocrine:				

Psychological:

Anxiety				
Depression				
Anorexia/Bulimia or eating disorder				
Postpartum depression				
Other Psychiatric Disorder:				

Heart History:

Heart Disease/arrhythmia/Murmur				
High blood pressure				
High Cholesterol				
Other Heart history:				

Patient's Past Medical History Continued: Please check Yes or No for any of the following current or past medical history. This is your personal history(not family history). Please indicate details where needed.

Respiratory / ENT History:	Yes	No	Date of Diagnosis	Details
Asthma or other Breathing problems				
Tuberculosis (TB)				
Allergies or Sinus disease				
Visual problems				
Hearing problems				

Neurology and Autoimmune:

Autoimmune disorder				
Migraines				
Neurological disorder				

Gastrointestinal History:

Liver/Bowel/Gallbladder disease				
IBS				
Colon Polyps				
Hemorrhoids				
Esophageal Reflux				
Other Gastrointestinal Disease:				

Bleeding/Blood Disorder:

Blood Clot or Pulmonary embolism				
Bleeding disorder				
Blood Transfusion History				
Anemia				

Skin Disorder:

Eczema, Psoriasis, other Skin Disorder				

Musculoskeletal:

Osteopenia or osteoporosis				
Broken Bones/Fractures (ANY type)				
Spine or joint problems				
Musculoskeletal Disorders:				

Viral/Infection:

Varicella (Chicken Pox)				
Shingles				
Hepatitis				
Lyme Disease				
Other serious infection or virus:				

ANY OTHER PAST MEDICAL HISTORY NOT LISTED: Yes No If Yes, Please list Details:

Smoking History (Please check which applies):

	Never	
	Quit	# Packs per day:______ # years smoked:__________ Quit Date:__________
	Current Smoker	# Packs per day:______ # years smoked:__________

Alcohol Usage (Please check which applies):

	None
	Yes # of drinks per week:_______ or other: Type: Beer Wine Alcohol

Illicit Drug Usage (Please check which applies):

	Never
	History of but none within the last 6 months Date and type of last usage:
	Current (within last 6 months) Type/Amount:
Have you ever had an alcohol or drug addiction problem? Yes No	
Exercise: Yes No Type/Amount (example: cardio/weights 2x a week):	
Do you perform a monthly self-breast exam? Yes No	
Have you ever been a Victim of Abuse? Yes No Sexual Physical Verbal Assault Date/age of abuse:	

Family History:

THIS IS FOR _YOUR_ PERSONAL FAMILY HISTORY ONLY. (Not your spouse's). Please indicate paternal (fathers side) or maternal(mother's side) for grandparents, aunts, uncles etc.

Breast Cancer	Y	N	Family Member(s)/Age of Diagnosis :
Ovarian Cancer	Y	N	Family Member(s)/Age of Diagnosis :
Uterine Cancer	Y	N	Family Member(s)/Age of Diagnosis :
Colon Cancer	Y	N	Family Member(s):
Cancer-Other type	Y	N	Family Member(s)/TYPE:
Gynecological Disorder	Y	N	Family Member(s)/TYPE:
Heart disease under age 65	Y	N	Family Member(s):
High Cholesterol	Y	N	Family Member(s):
Diabetes	Y	N	Family Member(s):
Autoimmune disease	Y	N	Family Member(s)/Type:
Thyroid Disease	Y	N	Family Member(s)/Type:
Blood clot or Bleeding Disorder	Y	N	Family Member(s)/Type:
High Blood Pressure	Y	N	Family Member(s):
Kidney/Renal Disease	Y	N	Family Member(s):
Osteoporosis	Y	N	Family Member(s):
Congenital/Birth defect	Y	N	Family Member(s)/Type:
Psychological disorder	Y	N	Family Member(s)/Type:
Other:	Y	N	Family Member(s):
Other:	Y	N	Family Member(s):

Signature:____ **Date**:____________________________________

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