Stefanie Mikulics M.D.

Confidential Health History

Name: _____ **Age:** _____ **Date of Visit:** _____

REASON FOR VISIT?

MEDICATION

Please list all Medications (Prescription and over the counter), herbs, supplements you take below:

Name:	How often?

ALLERGIES (meds, foods, environmental) and reaction that Occurred:

HOSPITALIZATIONS Please List, check if more than 6 ☐

1)	Mo./Yr. ___/___	Illness or Operation	_____	Place	_____
2)	Mo./Yr. ___/___	Illness or Operation	_____	Place	_____
3)	Mo./Yr. ___/___	Illness or Operation	_____	Place	_____
4)	Mo./Yr. ___/___	Illness or Operation	_____	Place	_____
5)	Mo./Yr. ___/___	Illness or Operation	_____	Place	_____
6)	Mo./Yr. ___/___	Illness or Operation	_____	Place	_____

GYN HISTORY

Last PAP _____ any previous abnormal? _____

Last MAMMO _____

Any history of STD (HPV, HSV) _____

Any history of ☐ PID ☐ Endometriosis ☐ Infertility ☐ PCOs

Age of menopause _____

Any concerns? _____

Have you ever had a breast lump or surgery? ○ Yes ○ No

Results/Treatment _____

Do you do Self Breast Examinations? _____

Any history of physical/sexual abuse? _____

Counseling? _____

Are you currently sexually active? ○ Yes ○ No

If no, have you been in the past? ○ Yes ○ No

More than 3 partners in lifetime? ○ Yes ○ No

Sexual partners are: ○ men ○ women ○ both

Any sexual concerns to discuss? _____

MENSTURAL HISTORY

First Period _____ Last Period _____

Frequency _____

Duration _____ days

Flow ○ Light ○ Moderate ○ Heavy

Cramping ☐

Bloating ☐

Moodiness ☐

Ovulatory pain ☐

Break thru bleeding ☐

CONTRACEPTIVE HISTORY

Current _____

Past OC's _____

PLEASE CHECK ONLY THOSE THAT APPLY

Current Health Status	current	occais.
Seasonal Allergies	○	○
Weight Change	○	○
Fever	○	○
Fatigue	○	○
Head		
Frequent Headaches	○	○
Migraine Headaches	○	○
Eyes		
Double Vision	○	○
Spots before eyes	○	○
Vision changes	○	○
Ear, Nose, Throat, Mouth		
Ear aches	○	○
Ringing in ears	○	○
Sinus problems	○	○
Sore throat	○	○
Mouth sores	○	○
Dental problems	○	○
Swollen glands	○	○
Cardiovascular		
Chest pain	○	○
Palpitations of heart	○	○
Difficulty breathing on exertion	○	○
Swelling of legs or bulging	○	○
Blood vessels in leg(s)	○	○
Respiratory	○	○
Wheezing or shortness of breath	○	○
Painful breathing	○	○
Cough, chronic	○	○
Spitting up blood	○	○
Gastrointestinal		
Nausea/vomiting	○	○
Diarrehea, frequency	○	○
Constipation	○	○
Rectal Bleeding	○	○
Hemoorhoids	○	○
Genito-Urinary		
Urgency	○	○
Frequency of urination	○	○
Pain with urination	○	○
Blood in urine	○	○
Incomplete emptying	○	○
Incontinence-Stress	○	○
(cough/sneeze/laugh) or w/ Urge	○	○
Painful intercouse	○	○
Irregular periods	○	○
Menstrual cramping	○	○
Vaginal burning/itching or discharge	○	○
Skin/Breast		
Breast nodules or masses	○	○
Pain in breast	○	○
Nipple discharge	○	○
Skin ulcers/breaks/Rash	○	○
Neurological		
Dizziness	○	○
Numbness/Weakness	○	○
Seizures	○	○
Trouble walking	○	○

Endocrine	current	occais.
Dry skin	○	○
Abnormal thirst	○	○
Memory loss/forgetfullness	○	○
Hot flashes/Night sweats	○	○
Insomnia	○	○
Hematological/Lymphatic		
Bruise easily	○	○
Cuts bleed prolonged time	○	○
Enlarged lymph nodes	○	○
Psychiatric		
Depression	○	○
Moody/Irritable	○	○
Crying, frequent	○	○

Personal Medical History

(Check all that apply)

- ☐ Abnormal Pap
- ☐ Cancer (Where _____)
- ☐ Breast lump
- ☐ Heartburn
- ☐ Migraine
- ☐ Frequent Headaches
- ☐ Diabetes
- ☐ Skin Lesions/Disorders
- ☐ Thyroid Disease
- ☐ Autoimmune Disease
- ☐ Frequent Bladder Infections
- ☐ Kidney Disease
- ☐ Gallbladder Problems
- ☐ Hernia (type _____)
- ☐ Depression
- ☐ Eating Disorder
- ☐ Depression/Anxiety
- ☐ Osteoporosis
- ☐ Eye Disorder
- ☐ Chron's/Ulcerative Colitis
- ☐ IBS
- ☐ Lung Disease
- ☐ Urinary Incontinence
- ☐ Heavy Periods
- ☐ Asthma
- ☐ Blood clot/DVT
- ☐ Rheumatic Fever
- ☐ Arthritis/joint pain
- ☐ Seizures/Epilepsy
- ☐ Alchohol/Substance abuse
- ☐ Heart Attach
- ☐ High Blood Pressure
- ☐ Anemia
- ☐ Pneumonia
- ☐ Chicken pox
- ☐ History of a Blood Transfusion
  Reason _____
- ☐ Kidney Stones
- ☐ Stroke
- ☐ High Blood Pressure
- ☐ Diverticulitis
- ☐ Thrombophilia
- ☐ Blood Disorders
- ☐ Melanoma
- ☐ Benign Tumors
- ☐ Other: _____

Infection History

(Check all that apply)

Hepatitis ☐A ☐B ☐C

- ☐ Syphillis
- ☐ Chlamydia
- ☐ HPV
- ☐ Condyloma/Venereal Warts
- ☐ Pelvic Infection
- ☐ HSV (herpes)
- ☐ Tuberculosis
- ☐ HIV
- ☐ Gonorrhea

OB History

# of Pregnancies _____ # of Births _____

Ages of Children _____

Birth Weights _____

# of Term _____ # of Preterm _____

Adopted _____ # of Miscarriages _____

of Abortions _____ # of Stillbirths _____

# of C Sections _____

_____

_____

_____

Social History

Smoker ☐ Past ☐ Present ☐ Never

packs/day _____ # years _____

Alcohol?

type _____ quantity _____ frequency _____

Drugs?

type _____ quantity _____ frequency _____

Regular exercise? ○yes ○no

type _____ frequency _____

Family History

Releative(s) affected Age of onset _____

Heart disease / attacks _____

High blood pressure _____

Stroke _____

Cancer (type of CA) _____

Diabetes _____

Osteoporosis _____

Mental Illness _____

Other _____

Completed By:

☐Patient ☐MA ☐N ☐MD ☐Other

Signature: _____

FOR OFFICE USE ONLY

Initial date reviwed with patient by NP/MD

Subsequent review with patient

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____

Date _____ Signature _____