19991 Hall Road, Suite 105 Macomb, MI 48044



Phone: 586-247-8609 Fax: 586-247-8615 e-Fax: 586-247-8613

HEALTH HISTORY

Asthma	ame:	Date of Birth:	Today's Date:
Althritis	ledical History (any new from last visit):	□None	
Occupation:	□Arthritis □Heart Murmur □Heart Disease □Stroke □Epilepsy □Migraines □Lupus	☐ High Blood Pressure ☐ HIV ☐ Kidney Disease ☐ Osteoporosis ☐ Cholesterol ☐ Thyroid Disease: Hyperthyroid ☐ Thyroid Disease: Hypothyroid	☐ Diabetes: Type 2 ☐ Polycystic Ovaries (PCOS) ☐ Endometriosis ☐ Uterine Fibroids ☐ Cancer (please specify type)
Do you use tobacco? Yes No Previously How many packs/cigarettes per day? Do you use alcohol? Yes No Previously How many drinks per day/week? Do you use drugs? Yes No Previously What kind? How often? First day of your last period: Age of first period: How many days between periods? Age of first period: How many days between periods? Age of first period: How many days between periods? Age of first period: How many days between periods? Age of first period: How many days between periods? Age of first period: How many days between periods? Age of first period: How many days between periods? Age of first period: How long do your periods last? Age of first period: How many drinks per day/week? Age of first period: Age of first per	ocial History: Single Married	d □Divorced □Widowed □Female Partner □M	Male Partner
Do you use alcohol? Yes	Occupation:	Student: \[Yes \] No	
Do you use drugs? Yes No Previously What kind? How often? How often? How first day of your last period: How many days between periods? How long do your periods last? Cramping during periods? Yes No Plow: Heavy Medium Light Clots: Yes No Pain level during periods (1= mild 10= severe) out of 10 Are you currently sexually active? Male Female Both Are you currently pregnant? Male Female Both Are you currently pregnant? What are you currently using for contraception? None What are you used previously? IUD Pills Condoms Patch Nuvaring Other: te of last pap smear: Normal Abnormal Date of last mammogram: Normal Abnormal How many times have you been pregnant? Number of children? Let of delivery Weeks at delivery C-Section/Vaginal Male/Female Baby's birth weight Complications Complications	Do you use tobacco? □Yes □No □P	reviously How many packs/cigarettes per day?	
First day of your last period: How many days between periods? How long do your periods last? Cramping during periods? Yes No Flow: Heavy Medium Light Clots: Yes No Pain level during periods (1= mild 10= severe) out of 10	Do you use alcohol? □Yes □No □P	reviously How many drinks per day/week?	
Age of first period: How many days between periods? How long do your periods last? Cramping during periods? Pain level during periods (1= mild 10= severe) out of 10 Are you currently sexually active? Male Permale Both Are you currently pregnant? Male Permale Both Are you currently pregnant? Permale Both Are you currently using for contraception? Paich are you currently using for contraception? Both Are you used previously? IUD Pills Condoms Patch Nuvraing Pormal Abnormal te of last pap smear: Normal Abnormal Date of last mammogram: Normal Abnormal Both Pormal Abnormal Baby's birth weight Complications To define the pregnant? Number of children? To define Baby's birth weight Complications To define Baby's birth weight Complications Baby's birth weight Baby's birth weight	Do you use drugs?□Yes □No □Prev	iously What kind? How	often?
Age of first period: How many days between periods? How long do your periods last? Cramping during periods? Plos	B/GYN History		
Age of first period: How many days between periods? How long do your periods last? Cramping during periods?			
Cramping during periods? Yes No Flow: Heavy Medium Light Clots: Yes No Pain level during periods (1= mild 10= severe)			your periods last?
Are you currently sexually active?	Cramping during periods? ☐ Yes ☐ No	Flow: ☐Heavy ☐Medium ☐Light	
Is your current sexual partner(s)?			
Are you currently pregnant?			
Do you have a history of sexually transmitted diseases? Yes No Please specify type:	• • • • • • • • • • • • • • • • • • • •		
What are you currently using for contraception? None What have you used previously? IUD Pills Condoms Patch Nuvaring Other: te of last pap smear: Normal Abnormal Date of last mammogram: Normal Abnormal te of last colonoscopy: Normal Abnormal Date of last bone density: Normal Abnormal How many times have you been pregnant? Number of children? te of delivery Weeks at delivery C-Section/Vaginal Male/Female Baby's birth weight Complications	, , , , ,		
What have you used previously? IUD			
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te of last colonoscopy: Normal Abnormal Date of last bone density: Normal Abnormal How many times have you been pregnant? Number of children? te of delivery Weeks at delivery C-Section/Vaginal Male/Female Baby's birth weight Complications	y p		·
How many times have you been pregnant? Number of children? te of delivery Weeks at delivery C-Section/Vaginal Male/Female Baby's birth weight Complications	ate of last pap smear: Nor	rmal Abnormal Date of last mammogram:	Normal
te of delivery Weeks at delivery C-Section/Vaginal Male/Female Baby's birth weight Complications	ate of last colonoscopy: \[\subseteq No	rmal □Abnormal Date of last bone density: _	Normal □Abnormal
	How many times have you been pregnant	? Number of children	?
	ate of delivery Weeks at delivery C-S	ection/Vaginal Male/Female Baby's birth weigh	t Complications
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19991 Hall Road, Suite 105 Macomb, MI 48044

Partriage Creek

Obstetrics Gynecology

HEALTH HISTORY CONTINUED

Phone: 586-247-8609 Fax: 586-247-8615 e-Fax: 586-247-8613

Surgical History (any new from last visit) □ None		Name:	Name:	
Date Type of Sur	rgery	Date	Type of Surg	gery
		_		
Medication (please include vit	amins, over the counter		one	
Medication		Dosage (mg, IU)		How often you take
Allergies (please include medi	cations, environmental, a	and food allergies)	□None	
Allergy Rea	ction (hives, swelling, etc.) Allergy	React	tion (hives, swelling, etc)
Family Medical History (any	new from last visit- pleas	e include relationship	to you- i.e. parents,	siblings, grandparents)
Diabetes: Type 1		Stroke		Ovarian Cancer
Diabetes: Type 1		☐Stroke		Ovarian Cancer
Diabetes: Type 1 Diabetes: Type 2 High Blood Pressure		Stroke		Ovarian Cancer
Diabetes: Type 1 Diabetes: Type 2 High Blood Pressure		☐Stroke		
Diabetes: Type 1 Diabetes: Type 2 High Blood Pressure Depression/Mental Illness		☐ Stroke ☐ Osteoporosis ☐ Lupus		Ovarian Cancer
Family Medical History (any part) Diabetes: Type 1 Diabetes: Type 2 High Blood Pressure Depression/Mental Illness Thyroid Disease: Hypothyroid	d	□ Stroke □ Osteoporosis □ Lupus □ Heart Disease □ Emphysema		☐Ovarian Cancer ☐Other Cancer (please specify
Diabetes: Type 1 Diabetes: Type 2 High Blood Pressure Depression/Mental Illness Thyroid Disease: Hypothyroid	d	☐ Stroke		☐Ovarian Cancer ☐Other Cancer (please specify
Diabetes: Type 1 Diabetes: Type 2 High Blood Pressure Depression/Mental Illness Thyroid Disease: Hypothyroi	d	☐ Stroke ☐ ☐ Osteoporosis ☐ ☐ Lupus ☐ Heart Disease ☐ ☐ Emphysema ☐ ☐ Breast Cancer ☐ ☐ Colon Cancer ☐ ☐		☐Ovarian Cancer ☐Other Cancer (please specify
Diabetes: Type 1 Diabetes: Type 2 High Blood Pressure Depression/Mental Illness Thyroid Disease: Hypothyroi Thyroid Disease: Hyperthyro Kidney Disease Review of Symptoms (please in	d id mark any symptoms or p	☐ Stroke ☐ ☐ Osteoporosis ☐ ☐ Lupus ☐ Heart Disease ☐ ☐ Emphysema ☐ ☐ Breast Cancer ☐ ☐ Colon Cancer ☐ ☐		□Ovarian Cancer □Other Cancer (please specify □Other (please specify) □Other (please specify)
Diabetes: Type 1 Diabetes: Type 2 High Blood Pressure Depression/Mental Illness Thyroid Disease: Hypothyroid Thyroid Disease: Hyperthyro Kidney Disease Review of Symptoms (please in the property) Tired/Fatigue	d	☐ Stroke ☐ Osteoporosis ☐ Lupus ☐ Heart Disease ☐ Emphysema ☐ Breast Cancer ☐ Colon Cancer roblems you are expe	riencing today)	□Ovarian Cancer □Other Cancer (please specify □Other (please specify) □Other (please specify)
Diabetes: Type 1 Diabetes: Type 2 High Blood Pressure Depression/Mental Illness Thyroid Disease: Hypothyroid Thyroid Disease: Hyperthyro Kidney Disease Review of Symptoms (please In the proof of the p	d id mark any symptoms or p □Joint Pain □Loss of hain	☐ Stroke ☐ Osteoporosis ☐ Lupus ☐ Heart Disease ☐ Emphysema ☐ Breast Cancer ☐ Colon Cancer roblems you are expe	riencing today)	☐Ovarian Cancer ☐☐Other Cancer (please specify☐☐Other (please specify)☐☐Other (please specify)☐Other (please specify)
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Diabetes: Type 1 Diabetes: Type 2 High Blood Pressure Depression/Mental Illness Thyroid Disease: Hypothyroid Thyroid Disease: Hyperthyroid Kidney Disease Review of Symptoms (please in the strength of the st	d id mark any symptoms or p □ Joint Pain □ Loss of hain □ Memory/co □ Decreased I □ Ringing in o □ Vomiting ise □ Blood in sto	Stroke Osteoporosis Lupus Heart Disease Emphysema Breast Cancer Colon Cancer roblems you are experimentation difficulty libido (sex drive) lears	riencing today) Incontinence Anxiety Difficulty sleep Weight loss Weight gain Lightheadednes	Ovarian Cancer Other Cancer (please specify Other (please specify) Other (please specify) No problems today
Diabetes: Type 1 Diabetes: Type 2 High Blood Pressure Depression/Mental Illness Thyroid Disease: Hypothyroid Thyroid Disease: Hyperthyroid Kidney Disease Review of Symptoms (please In Interdigue) Closs of appetite Bleeding from gums Headache Chest pain Shortness of breath Shortness of breath with exerce	d id mark any symptoms or p	Stroke Osteoporosis Lupus Heart Disease Emphysema Breast Cancer Colon Cancer roblems you are expe	riencing today) Incontinence Anxiety Difficulty sleep Weight loss Weight gain Lightheadednes Breast Lumps Breast tenderne	Ovarian Cancer Other Cancer (please specify Other (please specify) Other (please specify) No problems today ing
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Diabetes: Type 1 Diabetes: Type 2 High Blood Pressure Depression/Mental Illness Thyroid Disease: Hypothyroid Thyroid Disease: Hyperthyro Kidney Disease Review of Symptoms (please of Symptoms) Bleeding from gums Headache Chest pain Shortness of breath Shortness of breath Shortness of breath with exerce Nausea Frequent urination at night Urinary Frequency	d id mark any symptoms or p	□ Stroke □ □ Osteoporosis □ □ Lupus □ Heart Disease □ □ Emphysema □ □ Breast Cancer □ □ Colon Cancer □ roblems you are experies of the cold to heat ts	riencing today) Incontinence Anxiety Difficulty sleep Weight loss Ueight gain Lightheadednes Breast Lumps Breast tenderne Nipple discharg	Ovarian Cancer Other Cancer (please specify Other (please specify) Other (please specify) No problems today ing
Diabetes: Type 1 Diabetes: Type 2 High Blood Pressure Depression/Mental Illness Thyroid Disease: Hypothyroi Thyroid Disease: Hyperthyro Kidney Disease Review of Symptoms (please In Disease In Diseas	d id mark any symptoms or p	□ Stroke □ □ Osteoporosis □ □ Lupus □ Heart Disease □ □ Emphysema □ □ Breast Cancer □ □ Colon Cancer □ roblems you are experies of the cold to heat ts	riencing today) Incontinence Anxiety Difficulty sleep Weight loss Weight gain Lightheadednes Breast Lumps Breast tenderne Nipple discharg	Ovarian Cancer Other Cancer (please specify Other (please specify) Other (please specify) No problems today ing