INITIAL HISTORY. DOB: _____

MAUREEN GOLDMAN, CNP. BCB-PMD
DEBBIE MEYERS, CNP, MS / SAGE HEALTH CARE

NAME _____ AGE _____
OCCUPATION _____
OTHER PROVIDER(S) (including Alternative): _____

SIGNIFICIANTALLERGIES/REACTION: _____

SIGNIFICANT ILLNESS, SURGERY, ACCIDENTS

Date	Type
_____	_____
_____	_____
_____	_____

IMMUNIZATIONS (most recent): Gardasil x 3 _____
dTap _____ Zostavax _____ Pneumovax ___
Hepatitis B x 3 _____ Other _____

MEDICATIONS, VITAMINS, SUPPLEMENTS

_____ _____ _____
_____ _____ _____
_____ _____ _____

LIFESTYLE BEHAVIORS:
Do you smoke? ☐ Yes ☐ No Amount _____
Past Smoker? ☐ Yes ☐ No Amount _____
Years _____ Year quit _____
Caffeine type/use per day _____
Alcohol type/use per week _____
Exercise type/frequency _____

PREGNANCY HISTORY: (list number)
Pregnancies ___ Live Births ___ Still Living _____
C-Sections _____ Miscarriage _____ Abortions _____
Stillbirths _____ Tubal Pregnancies _____

PERSONAL GYN HISTORY:

Yes	No	
☐	☐	Ovary Problem
☐	☐	Uterus Problems
☐	☐	Sexually Transmitted Infection
☐	☐	Pain or other problems with sex
☐	☐	Irregular bleeding
☐	☐	Pain (describe)
☐	☐	Breast disease/problems
☐	☐	Abnormal mammogram?
		Date most recent mammogram:
☐	☐	Abnormal Pap smears
		Date most recent Pap smear:

FAMILY MEDICAL HISTORY

Yes	No		Relatives
☐	☐	Breast Cancer	
☐	☐	Ovarian Cancer	
☐	☐	Prostate Cancer	
☐	☐	Heart Attack < age 50	
☐	☐	High Blood Pressure	
☐	☐	High Cholesterol	
☐	☐	Colon Cancer	
☐	☐	Stomach Cancer	
☐	☐	Melanoma	
☐	☐	Osteoporosis	
☐	☐	Diabetes	
☐	☐	Thyroid Disease	
☐	☐	Mental Health Disease	
☐	☐	Alcoholism	
☐	☐	Other	

PERSONAL GENERAL MEDICAL HISTORY

Yes	No	
☐	☐	Migraine Headaches
☐	☐	Numbness/visual disturbance/dizziness
☐	☐	Seizures/epilepsy
☐	☐	Skin probiems
☐	☐	Chronic breathing problems/asthma
☐	☐	High cholesterol
☐	☐	High blood pressure
☐	☐	Heart disease or problems
☐	☐	Blood clots or stroke
☐	☐	Intestinal or stomach problems
☐	☐	Liver or Gallbladder disease
☐	☐	Bone/joint or muscle problems
☐	☐	Kidney or bladder problems
☐	☐	Anemia or blood disorder
☐	☐	Thyroid disease or problems
☐	☐	Diabetes (including with pregnancy)
☐	☐	Cancer
☐	☐	Mental Health Problem/Depression
☐	☐	Other:

Provider Signature _____ Date _____

NAME: DOB:

PERSONAL HISTORY

MAUREEN GOLDMAN, CNP, BCB-PMD
DEBBIE MEYERS, CNP, MS / SAGE HEALTH CARE

This is a personal history questionnaire. Answering these questions either on the form or discussing verbally is optional. This information may be beneficial for me to provide the best care for you. **All information provided is confidential.** No information will be shared with anyone without your written permission or a court order. These questions will not be copied without your permission.

If you are younger than 18 years of age, I am mandated to report to the local authorities if I suspect or have reason to believe you have been abused, neglected or hurt by an adult or someone older than you.

General Medical History	(circle below)		
Have you been tested for:	HIV	Hepatitis B	Hepatitis C
Have you tested positive for:	HIV	Hepatitis B	Hepatitis C

Personal History	Yes	No	N/A
Are you being hurt, kicked, hit or scared by anyone right now?	☐	☐	☐
During the past month, have you often been bothered by feeling down, depressed, or hopeless?	☐	☐	☐
During the past month, have you often been bothered by little interest or pleasure in doing things?	☐	☐	☐
Are you receiving counseling or therapy right now?	☐	☐	☐
Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐	☐
Have people annoyed you criticizing your drinking or drug use?	☐	☐	☐
Have you ever felt bad or guilty about your drinking or drug use?	☐	☐	☐
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐	☐
Do you feel you had a problem with drugs or alcohol in the past?	☐	☐	☐
Would you say that food dominates your life?	☐	☐	☐
Do you make yourself sick because you feel uncomfortably full?	☐	☐	☐
Do you worry that you have lost control over how much you eat?	☐	☐	☐
Have you recently lost more than 14 lbs. in a 3 month period?	☐	☐	☐
Do you believe yourself to be fat when others say you are too thin?	☐	☐	☐

Sexual History			
Have you ever been sexually active?	☐	☐	☐
Are you currently sexually active?	☐	☐	☐
If yes, more than one partner in past year?	☐	☐	☐
If yes, is this a new partner within past 3 months?	☐	☐	☐
If yes, do you have sex with: ☐ Men ☐ Women ☐ Both			
Have you ever been forced to have sex without your permission?	☐	☐	☐
If yes, did you talk to a counselor about it?	☐	☐	☐
If you are using birth control, what type? _____	☐	☐	☐

I decline need for discussion, information or referral at this time. _____ **(signature)**