



Aurora
Women's Health & Midwifery Services
COMPLETE HEALTH HISTORY

Name _____ Age _____ Date of birth _____ Date _____

MEDICATIONS: List prescribed and over the counter medications and supplements. Include dosages.

NAME OR TYPE	YEAR BEGIN	YEAR STOPPED	HELPED? Y/N	SIDE EFFECTS

ALLERGIES AND REACTIONS: List known or suspected reactions to foods, medications or environmental factors.

HISTORY: Do you have, or have you ever had any of the following?

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Neurological Disease | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> STD's |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Musculoskeletal Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression / Anxiety |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Urinary Tract Infections | <input type="checkbox"/> Infection | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Herpes | |
| <input type="checkbox"/> Gynecological problems | | | |

PAST ILLNESSES: Have you had any of the following?

- | | | | |
|--|--|------------------------------------|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Kidney Infection |
| <input type="checkbox"/> Fifth's Disease | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Other |

SURGERIES / HOSPITALIZATIONS / OR ACCIDENTS? (Include dates with your descriptions for all of the following)

Any Blood Transfusions? No Yes When? _____

How many times in your life have you taken antibiotics and for what?

Review of Systems – Aurora Women's Health

Gastrointestinal

indigestion, heartburn, vomiting, bowel regularity
/changes, nausea, belching, flatulence, blood in stool
other: _____

Lymph

Tender nodes, enlargement,
other: _____

Endocrine

heat/cold intolerance, weight change, increased thirst
or urination, hair changes, increased hat/glove/shoe
size,
other: _____

Female

LMP, changes in menses, pain with intercourse, new
partners, changes in contraception, menopausal
symptoms
other: _____

Mental Status

Loss concentration, difficulty sleeping, eating,
socialization, mood changes, suicidal thoughts,
headaches, fainting
other: _____

Health Habits

tobacco, alcohol, illicit drugs, diet, exercise; how often
and what kind _____, exposure to
herbicides or pesticides
other: _____

Health Maintenance

last PE, diagnostic tests: date, result, follow-up. Self
exams: breast, genital, testicular. Last pap smear,
mammogram
other: _____

Notes:

Signature: _____