OB/GYN - Valerie A. Knudsen MD

Family and Personal Health History Form

Please complete the following information as accurately as possible. If you cannot remember specific details, please give your best estimate. Circle bold answers and write in all information that applies to you. All of your information is confidential and will only be shared with our staff unless requested by you. Thank you.

Name: _____ **DOB:** ____ / ____ / _____ **Age:** _____

Height: _____ **Weight:** _____ **Reason for visit:** _____

Gynecologic History

Last Pap: ____ / ____ / _____ History of Abnormal Pap? **No Yes** Details: _____

Problems with Menstrual Periods? **No Yes** Details: _____

Frequency? (26 days? 28 days?) _____ First Day of Last Menstrual Period: ____ / ____ / _____

Age of First Period? _____ Date of Positive Pregnancy Test (if applicable): ____ / ____ /_____

Sexual Orientation: **Homosexual Heterosexual Bi-Sexual Other:** _____

Do you practice safe sex? **No Yes** # of Current Partners: _____ # to date: _____

History of S.T.D.'s? **No Chlamydia Herpes HPV Gonorrhea Other:** _____

What is your current method of Contraception? **None Pill IUD Other:** _____

History of Sterilization? **No Yes** Details: _____

History of Breast Disease? **No Yes** Details: _____

History of Endometriosis? **No Yes** What treatments?_____

History of Infertility? **No Yes** What tests and/or treatments? _____

Mammogram Done? **No Yes** Date: ____ / ____ / _____ Results : _____

Personal History

History of Domestic Violence? **No Yes** Perpetrator Name & Relationship: _____

Does the Perpetrator live with you? **No Yes** Is there a restraining order in place? **No Yes**

Ethnicity: **Caucasian Asian Native American Latino Hispanic Other:** _____

Are you adopted? **No Yes** Martial Status: **No Yes Single** Number of Children: _____

Health Maintenance

Cholesterol Screening Done? **No** **Yes** Date: _____ / _____ / _____ Results : _____

Colonoscopy Screening Done? **No** **Yes** Date: _____ / _____ / _____ Results : _____

Bone Density Scan Done? **No** **Yes** Date: _____ / _____ / _____ Results : _____

History of Alcohol or Drug Abuse? **No** **Yes** If yes, Details: _____

Recreational Drug Use: **No** **Yes** Type: _____ Have you used or shared needles? **No** **Yes**

Alcohol Use: **No** **Yes** Drinks Per Day: _____ Start Age: _____ Quit Date: _____ / _____ / _____

Tobacco Use: **No** **Yes** Packs Per Day: _____ Start Age: _____ Quit Date: _____ / _____ / _____

Regular Exercise: **No** **Yes** How Often? **Every day** **1-3 times a week** **2-4 times a month**

Current Medications

Medication Name	Dosage	Frequency	Reason for Taking the Medication

Medical Allergies

Medication Name	Allergic Reaction

Obstetric History

(Please include miscarriage/abortion history)

Year	City/State	Pregnancy Duration	Hours in Labor	Sex	Birth Weight	Type of Delivery	Complications

Genetic Screening & Diagnosis

Have you ever had any type of genetic screening or diagnosis of the following? Please circle below.

Thalassemia_____**No Yes Screening Only Diagnosed** Date Diagnosed: _____ / _____ / _____
(Italian, Greek, Mediterranean, or Asian Background)

Tay-Sachs_____**No Yes Screening Only Diagnosed** Date Diagnosed: _____ / _____ / _____
(EG, Jewish, Cajun, French, Canadian)

Neural Tube Defect____**No Yes Screening Only Diagnosed** Date Diagnosed: _____ / _____ / _____

Muscular Dystrophy___**No Yes Screening Only Diagnosed** Date Diagnosed: _____ / _____ / _____

Cystic Fibrosis_____**No Yes Screening Only Diagnosed** Date Diagnosed: _____ / _____ / _____

Congenital Heart Defect No Yes Screening Only Diagnosed Date Diagnosed: _____ / _____ / _____

Down Syndrome_____**No Yes Screening Only Diagnosed** Date Diagnosed: _____ / _____ / _____

Hemophilia_____**No Yes Screening Only Diagnosed** Date Diagnosed: _____ / _____ / _____

Sickle Cell _____**No Yes Screening Only Diagnosed** Date Diagnosed: _____ / _____ / _____
(African American)

Mental Defect/Autism__**No Yes Screening Only Diagnosed** Date Diagnosed: _____ / _____ / _____

Child with Birth Defect **No Yes Screening Only Diagnosed** Date Diagnosed: _____ / _____ / _____

Maternal Diabetes____**No Yes Screening Only Diagnosed** Date Diagnosed: _____ / _____ / _____

Surgical History & Hospitalizations

Year	City/State	Type of Surgery/ Reason for Hospitalization	Complications

Personal & Family History

Please check the box for self history and write in your relation for family members.

History	Family Member	Self	Details (age of diagnosis, complications, ect.)
High Blood Pressure or Vascular Disease (Varicose Veins, Blood clots ect.)			
Heart Disease (Heart Attack, Valve Issues, Irregular Heart Beat, ect.)			
Pulmonary Disease (Asthma, Emphysema, COPD, ect.)			
Diabetes (Type 1, Type 2, Insulin usage, ect.)			
Thyroid Disease (Overactive, Goiters, Graves, ect.)			
Gastrointestinal Disease (Hepatitis, Gallbladder, crohns, ect.)			
Kidney & Bladder Issues (Infections, Stones, Control, ect.)			
Neurological Issues (Migraines, Seizures, Strokes, ect.)			
Hematologic (Blood) Disease (Anemia, Leukemia, Clotting, ect.)			
Musculoskeletal Issues (Arthritis, Osteoporosis, ect.)			
Psychiatric / Emotional Issues (PMS, Anxiety, Depression, ect.)			
Female Cancers (breast, Cervical, Ovarian, ect.)			
Other Cancers Colon, Lungs, Prostate, ect.)			
Other (Autoimmune, Epilepsy, ect.)			

Are there any other issues you would like to address?

Questions, concerns, or other issues not previously addressed.

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