# Patient History Form

Vitae Clinic, Inc.

| **Patient Name:** | **Age:** | **Date of Birth:** |
|---|---|---|
| **Allergies:** Medication or Item (i.e. latex) | Reaction (What Happened) | When: |
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**Past Medical History (your personal history)** Please check all that apply; for items with more than one option, please circle the appropriate selection:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Autoimmune Disorder
- ☐ Kidney Disease/UTI
- ☐ Neurologic/Epilepsy
- ☐ Psychiatric/Anxiety
- ☐ Depression/Postpartum Dep
- ☐ Hepatitis/Liver Disease
- ☐ Varicosities/Blood Clots
- ☐ Thyroid Disease
- ☐ Trauma/Violence
- ☐ Blood Transfusion
- ☐ Rh Sensitivity
- ☐ Pulmonary (TB/asthma)
- ☐ Seasonal allergies
- ☐ Breast Disease
- ☐ Gynecological Surgeries
- ☐ Hospitalization/Operations
- ☐ Anesthesia Complications
- ☐ History of abnormal pap
- ☐ Uterine anomaly
- ☐ Infertility
- ☐ Reproductive Treatment
- ☐ Measles/Chicken Pox
- ☐ Anemia
- ☐ Bone/Joint disease
- ☐ Bowel Disease
- ☐ Lung Disease
- ☐ Stomach ulcer/acid reflux
- ☐ Migraines
- ☐ Stroke
- ☐ Cancer
- ☐ Other:_____

| **Surgical History/Hospitalizations:** Procedure/Hospital Admission | Reason | |
|---|---|---|
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**Pregnancy History:** (Includes all pregnancies)

| Number of pregnancies: | Miscarriages: | Abortions: |
|---|---|---|
| Ectopic Pregnancies: | Live Births: | |

**Past Pregnancies (**to be completed by all patients who have ever been pregnant and have not yet reached menopause)**:**

| Delivery Date | Wks pregnant | Length of labor | Birth Weight | Gender | Vaginal/ Cesarean | Anesthesia? | Complications: | Name |
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**Medications** (please list ALL medications you are currently taking) **:**

| **Name** | **Dose** | **Frequency** |
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**Gynecological History** (please check all that apply):

- ☐ Abnormal Pap Smear — If yes, when:_____
- ☐ Sexually Transmitted Infection — Which one(s):_____ Treated (Y/N):_____
- ☐ Contraception — If yes, which type(s):_____ How Long:_____
- ☐ PMS
- ☐ Abnormal Bleeding

General Questions:

Date of last pap smear:_____ Date of last mammogram:_____

Age at first period:_____ Number of sexual partners in lifetime:_____

**Social History:**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner

Name of Spouse (if applicable):_____ DOB:_____

Children's names (if applicable):_____

Your Occupation:_____

Check all that apply:

- ☐ Current smoker — If yes, how much:_____
- ☐ Drink Alcohol — If yes, what type:_____ How often:_____
- ☐ Drink Caffeine — If yes, what type:_____ How often:_____
- ☐ Use IV drugs — If yes, what type:_____ How often:_____
- ☐ Use Marijuana — If yes, how often:_____ Last used:_____
- ☐ History of Domestic Abuse — If yes, when_____ Currently safe:_____
- ☐ History of Sexual Abuse — If yes, when_____

**Family History** (please check all that apply and indicate which family member/side of family):

- ☐ Breast Cancer — Who:_____ Age:_____
- ☐ Ovarian Cancer — Who:_____ Age:_____
- ☐ Colon Cancer — Who:_____ Age:_____
- ☐ Endometrial Cancer — Who:_____ Age:_____
- ☐ Diabetes — Who:_____ Age:_____
- ☐ High Blood Pressure — Who:_____ Age:_____
- ☐ Heart Disease — Who:_____ Age:_____
- ☐ Stroke — Who:_____ Age:_____
- ☐ Thyroid Disease — Who:_____ Age:_____
- ☐ Osteoporosis — Who:_____ Age:_____

*If you are currently pregnant, please complete the following section:*

**Genetic History and Infection History** (Includes you, baby's father, and family members on both sides):

Please check all that apply and note which family member in the comments below:

- ☐ Thalassemia
- ☐ Neural tube defect
- ☐ Congenital Heart Defect
- ☐ Down Syndrome
- ☐ Tay Sachs
- ☐ Huntington's Chorea
- ☐ Mental Retardation/Autism
- ☐ Chromosomal Disorders
- ☐ Maternal Metabolic Disorders (Type I DM, PKU)
- ☐ Birth Defects (i.e. cleft lip)
- ☐ Recurrent loss/stillbirth
- ☐ Canavan Disease
- ☐ Familial Dysautonomia
- ☐ Sickle cell disease or trait
- ☐ Hemophilia/bleeding disorder
- ☐ Muscular Dystrophy
- ☐ Cystic Fibrosis
- ☐ Exposure to TB
- ☐ Genital herpes (you/partner)
- ☐ Hepatitis B or C (you)
- ☐ Gonorrhea/Chlamydia (you)
- ☐ HIV (you)
- ☐ Syphilis (you)

Comments:_____

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