Gentle Care Health Center

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Patient Health History

Name _____ Today's Date _____

Date of Birth _____ Allergies _____

Please indicate if you, personally, have had problems in any of these areas:

___ Migraines ___ Heart/Circulation ___ High Blood Pressure ___ Cancer

___ High Cholesterol ___ Lungs/Breathing ___ Digestion / Bowel ___ Diabetes

___ Thyroid ___ Seizures ___ Anxiety / Depression ___ Smoker

What surgeries or hospitalizations have you had? _____

What medicines / supplements do you currently use? _____

Please indicate if you, personally, have experienced any of the following:

___ Abnormal Pap Smear ___ Abnormal Mammogram ___ Pelvic Infections

___ Eating disorders ___ Physical/ Mental Abuse ___ Sexual Assault

Age at which you began menstruating:_____ Date of your most recent period:_____

Are your cycles fairly regular? _____ How many days do you bleed? _____

# of total positive pregnancies _____ How many live births? _____ Miscarriages? ___

Stillborn deliveries? ____ Elective terminations? ____

When was your last pap smear? _____ Mammogram? _____ Bone Density? _____

Please indicate if anyone in your family has had any of the following:

___ Cancer ___ Diabetes ___ Stroke ___ Osteoporosis

___ Heart Disease ___ Alzheimer's ___ Blood Clots ___Other significance

Have you ever discussed end-of-life options with your family?_____