Healthworks of the Central Coast
History Form

Name: Last Name, First	**DOB:**	**Date:**

Marital Status: Single Married Separated Widowed Divorced Partnered

Allergies to Medications: No Yes:

Current Birth Control Method:

Current Prescribed and Over The Counter Medication: No Yes:

Check and Briefly Explain any Current or Past Problems in the Following Areas N/A

Skin	Chest/Heart	Recent Changes in:
Head/Neck	Back	Weight
Ears, Nose, Throat	Intestinal	Ability to sleep
Lungs	Bladder	Past surgeries

Other pain/discomfort:

Women Only

Age when periods started:	First day of last period:
How often do your periods come:	[] Regular [] Irregular [] Spotting [] Painful [] Heavy

Number of: Pregnancies Live Births Miscarriages Terminations

Are you pregnant or breastfeeding?	Yes No
Have you had a D&C, hysterectomy, or cesarean?	Yes No
Any urinary tract, bladder, or kidney infections?	Yes No
Any blood in your urine or history of kidney disease?	Yes No
Any problems controlling your urine?	Yes No
Any hot flashes or night sweats?	Yes No
Do you get PMS?	Yes No
Do you have any breast tenderness, lumps, or nipple discharge?	Yes No

Date of last pap smear exam: Date of last mammogram:

If you are considering any hormonal birth control method, do you have any of the following: N/A

Blood clots/DVT's	Migraines	High Blood Pressure
Heart Attack	**>35** and smoke	High cholesterol
Cancer of breast, uterus, cervix, ovaries	Major injury to lower extremities	Gallbladder
Liver disease	Diabetes/HTN	Cardiac/Renal disease
Are you lactating		Hep A, B, C/Alcohol use

Men Only	
Any blood, pain, or burning when you urinate?	Yes No
Any discharge from penis?	Yes No
Have you had any kidney, bladder, or prostate infections?	Yes No
Any pain or swelling in testicles?	Yes No
Do you do self testicular exams?	Yes No

Social History:

Do you drink alcohol?	Yes No
Do you use tobacco?	Yes No

Age started: How much: Have you quit? Reason:

Do you use recreational drugs?	Yes No

Everything stated in this history form will be kept confidential and used only to assist in your care or treatment

Signature______________________________Date__________ Reviewed by:____________________Date:______