



HEALTH HISTORY

J. Kenneth Davis, M.D.

Name _____ Date _____

Please List 2 Emergency contacts not living with you:

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____

Reason for Seeing Doctor Today _____

Medical History

Allergies to medications _____

Current medications _____

Hospitalizations (not including pregnancies)

Month/Year	Illness or Operation	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Personal or Family History of

	You	Family		You	Family		You	Family
High Blood Press	___	___	Lung Disease	___	___	Blood Clots	___	___
Diabetes	___	___	Thyroid Problems	___	___	Hepatitis(type___)	___	___
Breast Cancer	___	___	Kidney/Urinary Problems	___	___	Blood Transfusion	___	___
Gyn Cancer	___	___	Stomach/bowel/gallbladder	___	___	Other	___	___

Please give details of the above _____

Do you smoke _____ Packs per day _____ Do you use alcohol _____ How much _____

Do you have history of _____ Yes No Type _____

Drug Abuse _____

Sexually Transmitted Diseases _____

Psychiatric Problems _____

OB/GYN History

Date of last Pap smear _____ Mammogram _____ First day of last period _____

Are you currently sexually active _____ Method of birth control _____

Age menstruation began _____ How often do you have period? Every _____ days.

How long does it last? _____ days.

Ever had an abnormal Pap smear? _____ If yes when? _____

Treatment _____

Pregnancy History

How many times have you been pregnant? _____ Number of children living _____

Number of term births _____ Premature births _____ Miscarriages _____ Elective Abortions _____

Describe any complications of pregnancy, labor or delivery

