St. Gianna Clinic

Truly Excellent. Always Faithful.™

Medical History Form

Today's Date: _____

Name: _____ DOB: _____

How did you hear about St. Gianna Clinic? (choose one)

- Physician_____
- Creighton Model Fertility*Care* Practitioner or NFP Instructor _____
- Patient/friend _____
- Clinic Newsletter
- Facebook
- Web search
- Billboard
- Ad in *The Compass*
- Parish flyer/announcement
- Radio
- Other _____

Who are your doctors?

List any other doctors you have seen in the last year:

Doctor:	Address:	Phone Number:

Medical History

1. **What is the reason for your visit?**

   _____

2. **Allergies**

   Are you allergic to any environmental factors or have seasonal allergies? ☐ No ☐ Yes

   ☐ No known medication allergies

Medication/Food	Reaction	Medication/Food	Reaction

3. **Current Medications (including prescriptions, Over-the-counter (OTC) medications, herbals, vitamins, supplements) Continue list on back if needed.**

☐ Not taking any prescription medications or supplements

Medication/Supplement Name	Dose	Route (Oral, IntraMuscular, Nasal, etc)	Frequency (how many times per day)

4. **Medical History (*check all that apply*)** ☐ No problems

	Abnormal EKG		Eczema		Loss of Hearing
	Acne		Endometriosis		Lymes Disease
	Adrenal Fatigue		Epilepsy/Seizures		Numbness or Tingling where? _____
	Anemia		Erectile Dysfunction		Migraines with Aura? _Y____N__
	Anesthesia complications		Fainting		Multiple Sclerosis
	Anxiety		Fatigue		Muscle Spasms
	Asthma		Fibromyalgia		Obesity
	Atrial fibrillation (Afib)		Glaucoma		Osteoporosis/Osteopenia
	Benign Prostatic Hyperplasia (BPH)		Heart attack (MI)		Polycystic Ovarian Syndrome (PCOS)
	Blood Transfusion		Heartburn (GERD)		Postpartum Anxiety, Depression, or OCD
	Cancer Type:_____		Heart Murmur		Premenstrual Syndrome
	Chicken Pox		Herniated Discs		Prostate Problems (high PSA)
	Chronic Obstructive Pulmonary Disease (COPD)		Herpes (canker sore or genital)		Pulmonary Embolism (PE)
	Concussion		Hyperlipidemia (high cholesterol)		Shingles
	Congenital heart disease		Hot Flashes		Sickle Cell Disease/trait
	Congestive heart failure (CHF)		Hypothyroidism		Spinal Cord Injury
	Constipation		Hypertension (high blood pressure)		Stroke
	Crohn's disease		Hyperthyroidism		Suicide Attempt
	Depression		Insomnia		Tinnitus (ringing in ears)
	Diabetes, Type 1		Irritable Bowel Syndrome (IBS)		Traumatic Brain Injury (TBI)
	Diabetes, Type 2		Kidney Disease Stage: _____		Ulcerative Colitis
	Dialysis		Kidney Stones		Urinary Tract Infections (UTI), frequent
	Diarrhea		Liver Disease		Vertigo
	Dizziness		Long Haul COVID19		Vision Loss or Blindness
	DVT (blood clots)		Loss of Taste or Smell		Von Willebrand's Disease

List any other medical problems:

_____

_____

_____

_____

5. Health Screening:

Last Colonoscopy _____ ☐ Polyps present

Last Pap Smear _____ With HPV screen _____ ☐ Normal ☐ Abnormal

Last Mammogram _____ ☐ Normal ☐ Abnormal

Last Bone Density _____ ☐ Normal ☐ Abnormal

6. **Surgical history** ☐ No surgeries

Date	Type of surgery	Hospital/Location	Surgeon

Have you ever been advised to have any surgical operation, which has not been done? ☐ Yes ☐ No

7. **Social history**

Marital Status *(check one)* : ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

What's your occupation?_____

Are there any hazards or risks of the job? _____

How many caffeinated beverages do you drink per day?_____

Do you smoke cigarettes? ☐ No ☐ Yes

If yes, how many packs per day? _____ For how many years? _____

Do you drink alcohol? ☐ No ☐ Yes

If yes, how many drinks per week? _____

Do you use street drugs? ☐ No ☐ Yes

If yes, what types? _____

Do you have pets? _____

Do you follow a special diet? (gluten free, dairy free, vegetarian, cardiac, carb, etc.)

_____

Any food sensitivities or intolerances?_____

Do you exercise? _____

If so, how frequently and what kind? _____

8. **Family history** ☐ No problems

Health Concern	Family Members
Allergies	
ALS	
Anemia	
Asthma	
Anxiety	
Atrial Fibrillation	
Breast Cancer	
Cancer (what kind)	
COPD	
Depression	
Diabetes Type 1	
Diabetes Type 2	
Endometriosis	
Glaucoma	
Heart Attack	
Heart Disease	
Heart Failure	
High Blood Pressure	
High Cholesterol	
Hypothyroidism	
Kidney Disease	
Liver Disease	
Multiple Sclerosis	
PCOS	

Please list anything else with family history not listed above:

_____

_____

_____

9. **Review of systems (*check any that you have recently experienced)*** ☐

None

General	☐ Weight gain ☐ Weight loss ☐ Lack of energy ☐ Fever ☐ Chills
Eyes	☐ Blurred vision ☐ Irritation ☐ Redness
Head & neck	☐ Hearing loss ☐ Ringing in Ears ☐ Snoring ☐ Voice changes ☐ Trouble Swallowing
Cardiovascular	☐ Chest pain ☐ Palpitations (racing heart rate) ☐ Fainting
Respiratory	☐ Cough ☐ Wheezing ☐ Shortness of breath ☐ Coughing up blood
Breasts	☐ Discharge (☐ Clear ☐ Bloody ☐ Milky) ☐ Lumps ☐ Pain
Gastrointestinal	☐ Nausea ☐ Vomiting ☐ Constipation ☐ Diarrhea ☐ Bloody Stool
Genitourinary	☐ Frequent urination ☐ Painful urination ☐ Bloody urine ☐ Incontinence ☐ Discharge ☐ Odor
Musculoskeletal	☐ Back pain ☐ Muscle pain ☐ Joint pain ☐ Weakness
Skin	☐ Rash ☐ Acne ☐ Changing mole (color/size/shape) ☐ Excess hair growth ☐ Hair loss
Neurologic	☐ Headache ☐ Dizziness ☐ Seizures ☐ Numbness/tingling ☐ Fatigue ☐ Insomnia
Psychological	☐ Abusive relationship (current) ☐ Eating disorder ☐ Anxiety ☐ Depression ☐ History of trauma (abuse, rape) ☐ OCD
Endocrine	☐ Hair loss ☐ Brittle nails ☐ Intolerance to hot or cold
Hematologic	☐ Easy bruising ☐ Bleeding easily (hard to stop) ☐ Enlarged lymph nodes
Other	

10. **Menstrual history**

Menstrual cycle pattern (*check all that apply):*

☐ Regular periods ☐ Irregular periods ☐ Spotting before periods ☐No periods

☐ Heavy periods ☐ Light periods ☐ Bleeding/spotting between periods

Are your periods bothersome? ☐ No ☐ Yes If yes, how long have they been this way? _____

_____

Age of your first period?_____

Date of last period (1st day of bleeding)? _____

How often do you have a period? (from day one to day one) _____

Do you need medication to bring on a period? ☐ No ☐ Yes

How many days of bleeding do you have on average? _____

How many days of heavy bleeding? _____

When bleeding is heaviest, how often do you have to change your pad or tampon (how many minutes/hours?)
_____

11. **Obstetrical history**

Total number of ALL pregnancies (including current pregnancy): _____
Number of full-term deliveries (>37 weeks): _____
Number of premature deliveries (<37 weeks): _____
What was the cause? _____
Have you had any stillbirths (>20 weeks)? ☐ No ☐ Yes
Number of miscarriages (<20 weeks): _____
Number of ectopic/tubal pregnancies: _____
Number of elective abortions: _____

List each pregnancy below (including miscarriages):

Date (month/year)	Gestational age	Birth weight	Boy/ Girl	Delivery type (Vaginal, C-Section, Forceps, Miscarriage)	Complications

Signature of patient Date Time

Signature of Legal Representative Date Time

Printed Name of Legal Representative Relationship to patient