



Heart of Illinois Obstetrics & Gynecology

1302 Franklin Avenue, Suite 2800, Normal, IL 61761
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HEALTH HISTORY SUMMARY

Patient Name:	DOB:	Age:	Date:
<input type="checkbox"/> New Patient	Married/Years _____ S W D Sep Spouse/Significant Other _____		
<input type="checkbox"/> Consult	Race _____ Religion _____		
<input type="checkbox"/> Established Patient	Education GED HS SC CD GD Other _____		
Referring Physician/ Primary Care Physician:		Occupation: (Adolescent) Lives with:	

SOCIAL HISTORY	
Smoking	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Former Smoker PPD Vaping Y or N
Alcohol	<input type="checkbox"/> No <input type="checkbox"/> Social Drinks per week/month
Street Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes Notes:
Exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Days per Week
Nutrition	<input type="checkbox"/> Excel <input type="checkbox"/> Good <input type="checkbox"/> Poor Notes:
Safety	Seatbelt <input type="checkbox"/> Yes <input type="checkbox"/> History of Abuse

ALLERGIES	NONE
Latex <input type="checkbox"/> IV Dye <input type="checkbox"/> PCN <input type="checkbox"/> Sulfa <input type="checkbox"/>	
Other:	

CURRENT MEDICATIONS / SUPPLEMENTS	

HOSPITALIZATION/SURGICAL HISTORY (please list procedure/hospitalization and year)	
<input type="checkbox"/> NONE	

GYNECOLOGIC HISTORY Last Menstrual Period: _____ <input type="checkbox"/> Hysterectomy <input type="checkbox"/> BSO <input type="checkbox"/> Menopause					
Age First Menses:	Menses every _____ days	Length:	Amount:	Cramps: <input type="checkbox"/> No <input type="checkbox"/> Yes	Clots: <input type="checkbox"/> No <input type="checkbox"/> Yes
Pap Smear History: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Year of last Pap smear: _____ Year of Abnormal pap: _____				Currently Sexually Active: Y/N	
Method of Contraception:				Total # of past sexual partners:	

PREGNANCY HISTORY		NONE					
#	Year	Sex	Weight	Weeks	Type of delivery	Pregnancy or Delivery Complications	
1							
2							
3							
4							
5							
6							
7							
8							

PERSONAL/FAMILY HISTORY			Patient	Family Member	None	Patient	Family Member	None
Birth Defects/Genetic Disorders						Pulmonary problems		
Diabetes						Kidney- urinary problems		
↑ Cholesterol						Musculoskeletal problems		
High Blood Pressure						Vein Problems		
Stroke						Anemia/Bleeding problems		
Heart Disease						Blood Transfusions		
Thyroid Disorders						Infectious diseases		
Osteoporosis/Osteopenia						Tuberculosis		
Seizure Disorders						STDs		
Autoimmune Disorder						Rheumatic fever		
Mental Disorders						Infertility		
Endometriosis/Other History						Other History		

CANCER HISTORY		<input type="checkbox"/> NONE
Female (breast, ovarian, uterine, cervical)	Family Member / age of diagnosis/living or deceased	
Other (colon, skin)		