CHUNG MEA HA, MD, PC

MEDICAL HISTORY (version 9/15/16)

Name_____ Preferred Name_____ Date of Birth_____

MEDICAL HISTORY: Have you EVER had any of the following?

_High cholesterol	_Lung disease	_Bleeding problems	_Seizure/epilepsy
_High blood pressure	_Asthma	_Anemia	_Headaches/migraines
_Heart disease/attack	_Pneumonia	_Sickle cell	_Depression/anxiety
_Stroke	_Tuberculosis	_Genetic disorder	_Drug/alcohol problem
_Kidney disease/infection	_Gall bladder problems	_Blood transfusion	_Diabetes
_Mitral valve prolapse	_Liver disease/hepatitis	_Blood clots(lungs/legs)	_Thyroid problem
_Arthritis	_Bladder infections	_Pelvic infections	_Cancer

_Other _____

MEDICATIONS: List ALL medications you are currently taking, include over-the-counter, vitamins, herbal remedies: _____
_____
_____

ALLERGIES: List ALL allergies to medications/latex and the reaction: _____
_____
_____

SURGERIES: List ALL surgeries with dates: _____
_____
_____

GYNECOLOGY: First period started age_____ Last period started (date)_____

Menstrual cycles are:	☐Regular	☐Irregular	☐Every__Days
Menstrual pain is:	☐None/Mild	☐Moderate	☐Severe
Menstrual flow is:	☐ None/Light	☐Moderate	☐Heavy ☐Lasts__Days

The last time I had intercourse was____ days/weeks/months/years. ☐Never
Current partner(s)? ☐Yes ☐No ☐Male ☐Female How long? _____

Birth Control Methods: ☐None ☐Calendar/rhythm method ☐Withdrawal ☐Condom
☐Pill ☐Patch ☐Vaginal ring ☐Depo Provera ☐Implanon/Nexplanon
☐IUD (Copper/Mirena/Skyla/Liletta) ☐Tubal ligation ☐Essure ☐Vasectomy

Have you ever had a sexually transmitted infection? ☐Never ☐Never tested
☐Chlamydia ☐Gonorrhea ☐Trichomonas ☐Herpes ☐Type 1 ☐Type 2 ☐Oral ☐Genital
☐HPV ☐Genital Warts ☐Hepatitis B ☐Hepatitis C ☐HIV ☐Syphilis

Have you ever had any of the following? ☐Ovarian cysts ☐Fibroids ☐Endometriosis ☐Polyp ☐PCOS

Last Pap Smear (date)_____ ☐Never ☐Normal ☐Abnormal ☐Atypical ☐Low grade ☐High grade
Treatment? ☐None ☐Colposcopy ☐Cryo (freezing) ☐LEEP ☐Cone ☐Laser

Last Mammogram (date)_____ ☐Never ☐Normal ☐Abnormal _____
Treatment/Biopsy? _____

Last Colonoscopy (date)_____ ☐Never ☐Normal ☐Abnormal _____

Last Bone density (DEXA) (date)_____ ☐Never ☐Normal ☐Osteopenia ☐Osteoporosis

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MEDICAL HISTORY

OBSTETRIC HISTORY ☐Never pregnant
Pregnancies in order, including miscarriage, ectopic (tubal), abortion, stillbirth and premature birth.

Year	M/F	Weight	Delivery Type (vaginal, cesarean, vacuum, forceps)	Problems (preterm, diabetes, high blood pressure, bleeding, infection)	Name/Age

Any more pregnancies than listed above? ☐ No ☐ Yes
Comments_____

FAMILY HISTORY: Please list any close relatives with a history of the following:

_High blood pressure _____
_Heart disease _____
_Stroke _____
_Diabetes _____
_Bleeding problems _____
_Blood clots in lungs/legs _____
_Family health history unknown
_Genetic disorders_____
_Colon polyps/cancer _____
_Breast cancer _____
_Uterine cancer _____
_Ovarian cancer _____
_Other _____
_Are you adopted? ☐ No ☐ Yes
Comments_____

SOCIAL HISTORY: Where are you from initially? _____How long in Alaska? _____

Tobacco	_No	_Yes	_____ #packs per day/week/month	Started age _____ Quit age _____
Alcohol	_No	_Yes	_____ #drinks per day/week/month	Type _____
Street Drugs	_No	_Yes	_____ amount per day/week/month	Type _____
Caffeine	_No	_Yes	_____ amount per day/week/month	Type _____

REVIEW OF SYSTEMS Do you feel generally healthy? ☐No ☐Yes
Do you currently have any of the following?

Fever/chills	_No _Yes	Frequent urination	_No _Yes
Weight loss	_No _Yes	Painful urination	_No _Yes
Chest pain	_No _Yes	Urinary urgency	_No _Yes
Shortness of breath	_No _Yes	Urinary leakage	_No _Yes
Cough	_No _Yes	Stool/gas leakage	_No _Yes
Heartburn/indigestion	_No _Yes	Upper abdominal pain	_No _Yes
Breast lumps	_No _Yes	Lower abdominal pain	_No _Yes
Bloody stools	_No _Yes	Painful intercourse	_No _Yes
Depression/Anxiety	_No _Yes	Vaginal discharge	_No _Yes

Other/Comments _____

Referring Provider _____ Primary Provider _____

Patient Signature _____ Today's Date _____

Clinician's Signature _____ Review Date _____