

TERESA LERCH FAMILY PRACTICE - HEALTH HISTORY

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Preferred name: \_\_\_\_\_ Pronouns: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Sex Assigned at Birth: Female/Male/Intersex Relationship Status: Single/Married/Partnered/Divorced/Separated/Other \_\_\_\_\_

What is the **ONE** most important symptom or concern you would like addressed today? \_\_\_\_\_

Gynecological history (if applicable):

First day of last menstrual period: _____ Periods are: <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy Periods come every _____ days and last _____ days Date of last pap smear: _____	Have you ever had an abnormal pap? YES/NO _____ Have you ever been pregnant? YES/NO _____ How many times? _____ How many children do you have? _____
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Urologic history (if applicable):

Have you ever had any of the following:		
<input type="checkbox"/> hernia	<input type="checkbox"/> undescended testicles	<input type="checkbox"/> problems achieving/maintaining erections
<input type="checkbox"/> vasectomy	<input type="checkbox"/> injury to the testicle	<input type="checkbox"/> problems urinating, starting stream or dribbling
<input type="checkbox"/> bladder/prostate surgery	<input type="checkbox"/> problems with ejaculation	<input type="checkbox"/> a family member with a fertility problem

Are you sexually active? YES/NO _____ Do you have any problems with sexual relations/drive? YES/NO If yes, explain _____ Are you interested in HIV/other STI testing? YES/NO _____	What is your sexual preference? _____ Method of birth control: _____ Have you ever had any of the following: <input type="checkbox"/> Genital Herpes <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> HIV <input type="checkbox"/> HPV <input type="checkbox"/> Syphilis
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Do you use any tobacco/nicotine products? YES/NO _____ Have you used any tobacco products in the past? _____ Please list: cigarettes/vape/zyn/other: _____ Do you use recreational drugs? YES/NO _____ Do you drink alcohol? How many drinks per week _____	Does your weight affect the way you feel about yourself? YES/NO _____ Do you restrict, binge, or purge? YES/NO _____ Do you exercise regularly? YES/NO _____
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Have you ever been physically or emotionally abused? YES/NO \_\_\_\_\_  
 In the past two weeks, have you had little interest or pleasure in doing things or felt depressed or hopeless? YES/NO \_\_\_\_\_  
 Have you ever been diagnosed with a mental illness? YES/NO \_\_\_\_\_

Please list current medications (including supplements): \_\_\_\_\_

Are you allergic to any medication(s)? YES/NO: \_\_\_\_\_

**Returning patients:** updates from the last year only. **New patients:** please complete.

Surgical history (procedure/year): \_\_\_\_\_

Family History (please indicate **who and age of diagnosis** of any family members with the following):

Diabetes \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Heart Attack \_\_\_\_\_  
 Stroke \_\_\_\_\_ Thyroid Disease \_\_\_\_\_ Breast Cancer \_\_\_\_\_  
 Seizures \_\_\_\_\_ Colon Cancer \_\_\_\_\_ Uterine/Ovarian Cancer \_\_\_\_\_  
 Osteoporosis \_\_\_\_\_ Blood Clot/Blood Disorders \_\_\_\_\_ Disordered Eating \_\_\_\_\_