Label Here	Date: _____ Clinician: _____

FAMILY TREE CLINIC
1919 Nicollet Avenue
Minneapolis, MN 55403
Phone: 612-473-0800

HEALTH HISTORY FORM

-Please complete to the best of your knowledge. If there are questions you don't know the answer to or are uncomfortable answering, you can leave them blank-

Patient Full Name _____ **Date of Birth** _____

You will be called this name at the clinic and when our staff contacts you by telephone.

Patient Legal Name: _____

This name will be used for prescriptions, lab orders and mail. Bills will be sent to your insurance company or mailing address by this name.

What was your sex assigned at birth? □ female □ male □ intersex

What pronouns do you use? □ she/her □ he/him □ they/them □ another pronoun _____

Allergies and Medications

Do you have any allergies?
□ latex □ shellfish / iodine
□ food: _____
□ medication (if yes, please list below)

Medication	**Reaction**
_____	_____
_____	_____
_____	_____

Please list any current medications and doses - including over the counter medications, birth control methods, herbs, supplements, and vitamins:

Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____

Personal Medical History

Have you ever been diagnosed with any of the following?

Past	**Current**		**Past**	**Current**		**Past**	**Current**	
□	□	ADD/ADHD	□	□	Coronary artery disease (heart disease/attack or stroke)	□	□	Hypertension (high blood pressure)
□	□	Anemia						
□	□	Anxiety	□	□	Depression	□	□	Inflammatory bowel disease (Crohn's, Ulcerative Colitis)
□	□	Arthritis	□	□	Diabetes			
□	□	Asthma	□	□	Eating Disorder	□	□	Irritable bowel syndrome
□	□	Autism	□	□	Elevated (high) cholesterol	□	□	Osteoporosis
□	□	Bipolar Disorder	□	□	Gallbladder disease	□	□	Pelvic Inflammatory Disease
□	□	Blood clots / bleeding disorders	□	□	GERD (reflux / heartburn)	□	□	Renal / Kidney disease
□	□	Cancer	□	□	Headaches	□	□	Seizure disorder
□	□	Breast lump	□	□	Hepatitis / Liver disease	□	□	Thyroid disease
□	□	Substance Use Disorder	□	□	HIV	□	□	Urinary tract / Bladder infection

Do you have any autoimmune diseases? □ yes □ no
If yes, please describe: _____

Any other medical conditions? □ yes □ no
If yes, please describe: _____

Have you ever had surgery? □ yes □ no
If yes, please describe: _____

Have you ever been hospitalized? □ yes □ no
If yes, please describe: _____

Have you experienced any emotional, physical, or sexual abuse or assault? □ yes □ no
Do you want to discuss this today? □ yes □ no

OVER →

Medical History Continued

Do you smoke or use nicotine? □ yes □ no
If yes, are you interested in quitting? □ yes □ no
Do you drink alcohol? □ yes □ no

Do you use recreational drugs? □ yes □ no
Have you ever used needles to take drugs? □ yes □ no
If yes, do you share needles? □ yes □ no

Family Medical History

Check if you: □ do not know any biological family medical history □ are adopted

Check any relatives with the following:	Mother	Father	Sibling(s)	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Blood disease / clots							
Cancer							
Heart disease							
Diabetes							
High Cholesterol							
Hypertension (high blood pressure)							
Stroke							
Other							

Sexual Health and Family Planning

Do you or your partner(s) want to be pregnant?
□ now □ in the future □ never □ unsure
Are you or your partner(s) using a method of birth control?
□ yes □ no If yes, what method? _____

Check any methods of birth control you have ever used:

□ Birth Control Pills	□ Depo (The Shot)
□ Vaginal Ring (Nuva Ring)	□ The Patch
□ Condoms	□ Spermicide / Phexxi
□ Diaphragm	□ Fertility Awareness
□ Cervical Cap	□ Withdrawal (pull-out)
□ Implant / Nexplanon	□ IUD
□ Tubal Ligation/Hysterectomy	□ Vasectomy

Have you ever been sexually active? □ yes □ no
If yes, please answer the following:
Do your partner(s) have: □ penis □ vagina
How many people have you had sex with in the last:
3 months _____ 12 months _____

Check if you have had any of the following:

□ Chlamydia	□ Herpes
□ Gonorrhea	□ Hepatitis B or C
□ Genital Warts / HPV	□ Syphilis
□ Trichomonas	□ Other

What types of sexual activities do you practice?

□ Anal	□ insertive	□ receptive
□ Oral	□ insertive	□ receptive
□ Vaginal	□ insertive	□ receptive

Gynecological History

Menstrual History:
Age when periods started: _____
When did your last period start? _____
Periods come every _____ days and last _____ days
Periods are usually: □light □moderate □heavy □irregular

For Ages 40 and Over:
Have you ever had a mammogram? □ yes □ no
If yes, was it normal? □ yes □ no
If no, please describe: _____
Do you have any concerns about menopause symptoms?
□ yes □ no If yes, please describe: _____
_____

Have you ever had a Pap smear? □ yes □ no
If yes, when was your last Pap smear? _____
Have you ever had an abnormal Pap? □ yes □ no
If yes, please describe: _____

Pregnancy History:
Are you pregnant now? □ yes □ no □ unsure
Have you ever been pregnant? □ yes □ no
If yes, how many times? _____
# of live births _____ # of abortions _____
# of miscarriages _____ # of ectopic _____
Any problems with pregnancy or birth? □ yes □ no
If yes, please describe: _____

Is there any other information that is relevant to your visit today? _____
_____