KATZ AND KADE, INC.
71 E. HOLLISTER ST.
CINCINNATI, OH 45219

HEALTH HISTORY

SURGICAL HISTORY

Please list any surgeries you have had	Year

MEDICATION HISTORY

Medications currently taken on a regular basis (including any over-the-counter medications, Vitamins, and herbal supplements):

Name of Medication	I take this for (e.g. High BP)	Dosage (e.g., 10 mg)	Amount/ # of tablets daily (e.g. two tablets twice a day)

ALLERGIES

Including medications, latex, foods, etc.	Reaction is: (e.g.“rash”, “hives”, “shortness of breath” etc)

VACCINATIONS

Influenza (flu)	Approximate date received:
Herpes Zoster (shingles)	Approximate date received:
Pneumococcal (pneumonia)	Approximate date received:
Gardasil (prevents high-risk genital warts)	Approximate date received:
Cervarix (prevents high-risk genital warts)	Approximate date received:
Tetanus	Approximate date received:
DTaP (diphtheria, tetanus, pertussis)	Approximate date received:

PAST MEDICAL HISTORY

	Check One	Notes
Anemia or blood disorder	□Yes □No	
Arthritis	□Yes □No	
Birth defects or inherited disease	□Yes □No	
Cancer (if yes, please specify in the notes field)	□Yes □No	
Convulsions / seizures /fainting	□Yes □No	
Depression	□Yes □No	
Diabetes	□Yes □No	
Ear problems	□Yes □No	
Eye problems	□Yes □No	
GI problems	□Yes □No	
Headaches / migraines	□Yes □No	
Heart condition	□Yes □No	
Hepatitis	□Yes □No	
High blood pressure	□Yes □No	
High cholesterol	□Yes □No	
Hyperthyroidism	□Yes □No	
Hypothyroidism	□Yes □No	
Kidney or bladder problems	□Yes □No	
Lung disorder or asthma	□Yes □No	
Nose or throat problems	□Yes □No	
Varicosities	□Yes □No	
Other significant conditions: (*please indicate)* ____ ____	□Yes □No	

SOCIAL HISTORY (please complete or circle)

Occupation								
Exercise type and frequency								
Alcohol intake per week								
Smoking status	Never			Former			Current	
Smoking (packs per day/week)	1 ppw	2ppw	¼ ppd	½ ppd	1 ppd	1 ½ ppd	2 ppd	3+ ppd
History of abuse or current abuse (sexual, physical, etc.)	Yes	No		Notes:				
Are you safe?	Yes			No				
Marital status	Married	Divorced	Single	Widowed	Separated			
Are you currently sexually active?	Yes				No			
If you are not sexually active, have you ever been sexually active?	Yes				No			
New sexual partner in the last year?	Yes				No			
Contraceptive method								
Sexual orientation	Heterosexual			Lesbian			Bisexual	
Notes:								

FAMILY MEDICAL HISTORY

We're particularly interested in the medical history of the following family members:

Mother=M	Maternal grandmother=MGM	Maternal aunt=MA
Father=F	Maternal grandfather=MGF	Maternal Uncle=MU
Sister=S	Paternal grandmother=PGM	Paternal aunt=PA
Brother=B	Paternal grandfather=PGF	Paternal Uncle=PU

Please use these abbreviations in the grid below. If your relative is deceased please circle above and indicate the age at which they died.

Condition	Relationship
Breast cancer	
Colon cancer	
Ovarian, endometrial or uterine cancer	
Other cancer	
Heart disease/heart attack	
High blood pressure,	
High cholesterol	
Stroke	
Blood clot in leg or lung	
Blood clotting disorder or varicosities	
Diabetes	
Hip fracture or osteoporosis	
Thyroid problems	
Kidney disease	
Neurologic problems	
Depression/psychiatric problems	
Alzheimer's/ dementia	
Alcoholism	
Other:	

GYNECOLOGICAL HISTORY (please complete or circle)

					Notes:
Last menstrual period	/ /				
Colonoscopy	Yes		No		
Colonoscopy results	Normal	Diverticu-losis	Polyps	Other	
Date of last Pap					
Was the last Pap abnormal	Yes		No		
Date of last mammogram					
Was the last mammogram abnormal	Yes		No		
Fibrocystic breasts or benign breast problems	Yes		No		
History of breast cancer or abnormal breast biopsy	Yes		No		
If post-menopausal, age at menopause					
Age at menarche					
Flow	Light	Moderate	Heavy		
Duration of flow (days)					
Frequency of cycle (days)					

History of abnormal bleeding	Post-coital	Post-menopausal	Between cycles	Irregular cycles	
Clotting disorder	Yes		No		
Menstrual cramps	Yes		No		
PMS	Yes		No		
Sexual dysfunction	Decreased libido	Pain with intercourse	Arousal difficulties		
Did your mother take DES while pregnant with you?	Yes		No		
History of STD(s)	Yes		No		
History of HPV/genital warts	Yes		No		
PID	Yes		No		
Vulvar disease	Yes		No		
History of ovarian cysts	Yes		No		
Uterine abnormalities	Yes		No		
Endometriosis	Yes		No		
History of ectopic pregnancy	Yes		No		
Infertility	Yes		No		
Pelvic relaxation	Yes		No		
Gynecological cancer	Ovarian	Uterine	Cervical	Vulvar	
Urinary problems	Yes		No		
Bone fracture	Yes		No		
Have you had a bone density scan (dexascan)?	Yes		No		
Has you mother or sister had a hip fracture?	Yes		No		

OBSTETRIC HISTORY

Total Number of Pregnancies	Full-Term	Pre-Term	Abortion	Ectopic	Multiple	Living

Pharmacy Name: ______________________ Location: _____________________ Phone #: __________________

Primary Care Physician: ________________________ Phone #_______________________________

Specialty Physician: ___________________________ Phone #_______________________________

Patient Signature: ____ Date: ___________________________