

# PATIENT MEDICAL HISTORY

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF VISIT: \_\_\_\_\_  
 SENT BY DR.: \_\_\_\_\_ Reason for today's visit: \_\_\_\_\_

## MEDICAL - GYNECOLOGICAL HISTORY

Check all that apply. If Family Member, please note relationship (i.e. father, sister, etc.)

	P	F		P	F		P	F
BLOOD TRANSFUSIONS			BOWEL PROBLEMS			ABNORMAL PAP		
HIGH CHOLESTEROL			THYROID DISEASE			SYPHILIS		
HIGH BLOOD PRESSURE			IMMUNE SYSTEM DISORDER			BACTERIAL VAGINOSIS		
STROKE			LYMPH SYSTEM DISORDER			BLEEDING AFTER INTERCOURSE		
MIGRAINE HEADACHES			LUNG DISEASE			BREAST PROBLEMS		
BLOOD CLOTS			ASTHMA			CHLAMYDIA/GONORRHEA		
HEART DISEASE			KIDNEY/BLADDER PROBLEMS			CONDYLOMA		
HEART MURMUR			LIVERR/GALLBLADDER PROBLEMS			DES EXPOSURE		
HEART PALPITATIONS			SEIZURE DISORDER			DOUCHING		
BLEEDING DISORDER			VARICOSE VEINS/PHLEBITIS			ENDOMETRIOSIS		
ANEMIA			ARTHRITIS			GENITAL HERPES		
DIABETES			MENTAL DISABILITIES			INFERTILITY		
BREAST CANCER			BIRTH DEFECTS			LOSS OF URINE		
OVARIAN CANCER			WEIGHT PROBLEMS			OVARIAN CYSTS		
COLON CANCER			CAFFEINE USE			PELVIC OR TUBUAL INFECTIONS		
OTHER CANCERS			OTHER SUBSTANCE USE			PELVIC PROLAPSE		
RADIATION TREATMENTS			TRICHOMONAS			RECURRENT YEAST		
ULCERS/STOMACH PROBLEMS			ABNORMAL MAMMOGRAM			UTERINE FIBROIDS		

Other Medical Information: \_\_\_\_\_

## MENSTRUAL – CONTRACEPTIVE HISTORY (Check if present)

Age at Onset: \_\_\_\_\_ Cycle: \_\_\_\_\_ Length: \_\_\_\_\_ Date of Last Menstrual Period: \_\_\_\_\_

HEAVY PERIODS	NATURAL FAMILY PLANNING	STERILIZATION	DATE:
FREQUENT PERIODS	BARRIER	IUD	
SPOTTING BETWEEN PERIODS	DEPO PROVERA INJECTION	CURRENT METHOD:	
PAINFUL PERIODS	NORPLANT	LAST DATE USED:	
PMS	ORAL CONTRACEPTIVES		

Last Pap: \_\_\_\_\_ Results: \_\_\_\_\_ Last Mammo: \_\_\_\_\_ Results: \_\_\_\_\_ Last Bone Density \_\_\_\_\_ Results: \_\_\_\_\_ Last Colonoscopy: \_\_\_\_\_

## PREGNANCY HISTORY

Specify number of: Pregnancies: \_\_\_\_\_ Children born alive: \_\_\_\_\_ Miscarriages: \_\_\_\_\_  
 Abortions: \_\_\_\_\_ Ectopic: \_\_\_\_\_ Date of last delivery: \_\_\_\_\_  
 # of Vaginal deliveries: \_\_\_\_\_ # of Cesarean deliveries: \_\_\_\_\_

## SEXUAL HISTORY (Circle all the apply)

Are you sexually active?  Yes  No Frequency: \_\_\_\_\_ Questions: \_\_\_\_\_  
 Unprotected Intercourse  Pain with Intercourse  Anorgasmia  Multiple Partners  
 Physical/Sexual Abuse  Other, \_\_\_\_\_

## SOCIAL HISTORY

Married No. of years: \_\_\_\_\_ No. of times: \_\_\_\_\_  Single  Separated  Divorced  Widowed  
 Occupation: \_\_\_\_\_  
 Do you SMOKE?  YES  NO If yes, how much? \_\_\_\_\_ Do you use STREET DRUGS?  YES  NO  
 How much ALCOHOL do you drink? \_\_\_\_\_  
 Do you exercise regularly?  YES  NO If yes, describe: \_\_\_\_\_

## ALLERGIES TO MEDICATIONS:

\_\_\_\_\_

## PRESCRIPTIONS - OVER THE COUNTER MEDICATIONS:

\_\_\_\_\_

## PREVIOUS HOSPITALIZATIONS OR SURGERIES (Other than childbirth):

\_\_\_\_\_