OB/GYNE
Associates of Lake Forest, Ltd.

Patient Medical History Form

Name:	Date of Birth:	Date:

NAME OF CHILD	DATE OF DELIVERY MM/DD/YYYY	HOW MANY WEEKS AT DELIVERY	C-SEC OR VAG	M/F & WEIGHT	TYPE OF ANESTHESIA	HOSPITAL	COMPLICATIONS
#1							
#2							
#3							
#4							
#5							
#6							

History of miscarriages? ☐ Yes ☐ No **# of miscarriages ______ Was a D&C required? (If yes) Date: ___________**
History of abortions? ☐ Yes ☐ No **# of abortions ______**

GYNECOLOGICAL HISTORY
Age of first period? **Date of last menstrual period?**
How often do you get your period? (i.e. every 2 weeks, every month?)
How many days does your period last?
How many pads and/or tampons do you use on an average day?
Cramps/pain? What medications do you use?
Contraceptive method currently being used? ☐ Patch ☐ Vasectomy ☐ Ring ☐ Depo ☐ Condoms ☐ Natural Family Planning ☐ Rhythm ☐ Withdrawal ☐ IUD (type) ____________________ ☐ Pill (type)_________________________________
Sexually Transmitted Infections? ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ HPV **Was this treated?** Yes ☐ No ☐
Sexual Dysfunction problems?

SOCIAL HISTORY
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Same Sex Partner
Age of first intercourse? _____ # of partners _____
Currently sexually active? ☐ Yes ☐ No with Male ☐ with Female ☐ with Both ☐
Domestic abuse? ☐ Yes ☐ No
Sexual abuse? ☐ Yes ☐ No
Smoking? ☐ Yes ☐ No **# of packs per day ____ # of years used ____**
Alcohol? ☐ Yes ☐ No **# of drinks per day ____ # of drinks per week ____**
Substance Abuse? ☐ Yes ☐ No

Name: ____

	IF YOU CHECK YES TO ANY OF THE FOLLOWING, PLEASE PROVIDE THE DATE
Appendectomy	☐ Yes ☐ No Date:
Gall Bladder removal	☐ Yes ☐ No Date:
Breast surgery ☐ Yes ☐ No	If so, please check the following and was result cancerous of not: Biopsy: ☐ Yes ☐ No Right Breast ☐ Left Breast ☐ Date : ___________ Mastectomy: ☐ Yes ☐ No Right Breast ☐ Left Breast ☐ Date: ___________ Lumpectomy: ☐ Yes ☐ No Right Breast ☐ Left Breast ☐ Date: ___________
Total Abdominal Hysterectomy	☐ Yes ☐ No (see below for ovaries) Date: _______________
Vaginal Hysterectomy	☐ Yes ☐ No (see below for ovaries) Date: _______________
Laparoscopy	☐ Yes ☐ No Date: Ovarian cysts: ☐ Yes ☐ No Right ☐ Left ☐ Both ☐ Endometriosis: ☐ Yes ☐ No
Removal of ovaries	☐ Yes ☐ No Right ☐ Left ☐ Both ☐ Date:
Cervical cryotherapy (freeze)	☐ Yes ☐ No Date:
Cervical LEEP cone	☐ Yes ☐ No Date:
Cervical cone biopsy	☐ Yes ☐ No Date:
Any other surgeries	☐ Yes ☐ No If yes, please list below
#1	Date:
#2	Date:
#3	Date:

FAMILY HISTORY
Breast cancer ☐ Yes ☐ No ☐ Maternal ☐ Paternal Who? **Age of diagnosis?** Still alive? ☐ Yes ☐ No Age of death
Ovarian cancer ☐ Yes ☐ No ☐ Maternal ☐ Paternal Who? **Age of diagnosis?** Still alive? ☐ Yes ☐ No Age of death
Colon cancer ☐ Yes ☐ No ☐ Maternal ☐ Paternal Who? **Age of diagnosis?** Still alive? ☐ Yes ☐ No Age of death?
Heart disease ☐ Yes ☐ No ☐ Maternal ☐ Paternal Who? **Age of diagnosis?** Still alive? ☐ Yes ☐ No Age of death?
Diabetes ☐ Yes ☐ No ☐ Maternal ☐ Paternal Who? **Age of diagnosis?** Still alive? ☐ Yes ☐ No Age of death?

ANY ALLERGIES (PLEASE LIST BELOW)

Name:____

MEDICAL HISTORY	(PLEASE CHECK ALL THAT APPLY TO YOU)
Cardiovascular:	☐ Heart Attack ☐ Artery disease ☐ Angina ☐ CHF ☐ High BP ☐ High Cholesterol
Endocrine:	☐ Diabetes ☐ Low Thyroid ☐ High Thyroid
Respiratory:	☐ Asthma ☐ Allergies
Immune:	☐ HIV+
Gastrointestinal:	☐ Reflux ☐ Hepatitis ☐ Irritable Bowel ☐ Colitis
Genitourinary:	☐ Stones ☐ Kidney infection ☐ Chronic UTI
Musculoskeletal:	☐ Arthritis ☐ Osteoporosis ☐ Osteopenia
Psychiatric:	☐ Depression ☐ Anxiety ☐ PMS ☐ Bipolar ☐ Post-partum depression
Neurological:	☐ Stroke ☐ Mini-stroke ☐ M.S. ☐ Seizures ☐ Migraines
Rheumatology:	☐ Fibromyalgia ☐ Lupus
Hematology/oncology:	☐ Factor 5 ☐ MTHFR ☐ Blood clots/thrombophilia

PLEASE LIST ANY MEDICATIONS AND HERBAL SUPPLEMENTS THAT YOU TAKE	DOSE	HOW FREQUENTLY (PLEASE LIST HERBAL SUPPLEMENTS ALSO)

Name and location of pharmacy that you use: ____

Phone number of pharmacy: ____

Patient Health Questionnaire-2 (PHQ-2):

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1.) Little interest or pleasure in doing things	0	1	2	3
2.) Feeling down, depressed or hopeless	0	1	2	3

Score: _______

M.A. Initials: _________