Medical History

Date_____ Name _____ Age_____ Date of birth _____
Primary care doctor name and address_____

Medical History: Have you ever had any of the following:

___Genetic conditions or birth defects
___Heart Disease or heart murmur
___Chest pain
___Shortness of breath
___High blood pressure
___Diabetes
___High cholesterol
___Frequent headaches/migraines
___Gastrointestinal problems
___Constipation
___Rectal bleeding
___Gallbladder problems
___Liver problems
___Anemia
___Asthma
___Psychiatric care
___Depression or anxiety
___Alcoholism or drug dependency
___Frequent urinary tract infections
___Kidney infections
___Kidney stone
___Lupus or fibromyalgia
___Arthritis
___Spine, hip or knee problems
___Breast disease
___Osteoporosis
___Unintentional, rapid weight loss or gain
___Thyroid problems
___Skin rashes
___Epilepsy/convulsions
___Tuberculosis
___Blood transfusion
___Problems with anesthetics

Cancer: ___Uterus ___Breast ___Cervix ___Colon ___Ovary Other: _____

Medications (including over the counter and supplements):

Name	Dose	How often	Purpose

Drug Allergies:

Name	Reaction

Obstetric and Gynecologic history:

Pregnancy History (include miscarriage, ectopic pregnancy, abortion, and pregnancies):

Year, Vaginal or C-section	Weeks/Months (how far along were you?)	Gender/Weight	Complications?

First day of last menstrual period_____ Age first period began_____
Do you have bleeding between periods? _____Yes _____No
How many days between periods_____ Regular cycles? _____
How many days do your periods last?_____ Number of pads/tampons on your heaviest day_____
Do you have painful cramps that stop you from taking care of daily responsibilities? ___Yes ___No

Do you have:
___Recurrent vaginal infections (yeast or BV)
History of STDs (Gonorrhea, Chlamydia, Herpes, genital warts, HIV, etc): _____
___Pain with intercourse
Are you sexually active? ____Yes ____No If not, since when? _____
How long have you been with your current sexual partner? _____
Is (Are) your partner(s) _____Male ____Female _____Both
Age at first intercourse _____ Number of sexual partners in your life _____
Do you have (or have a history of):

___Fibroids
___Endometriosis
___Infection of pelvic organs
___Pelvic pain
___Nipple discharge
___Breast cyst/mass/pain
___Blood in your urine
___Leakage of urine or frequent urination

___Hot flashes or problems sleeping
Birth control method (pills, condoms, IUD, natural family planning, etc): _____
Other birth control methods you have used in the past: _____
Are you satisfied with your birth control? _____

Surgical History and Hospitalization:

Date	Length of Stay	Illness or Operation	Anesthesia	Complications

Social History:
Are you: ___Single ___Married ___Divorced ___Widowed
Do you: Smoke Cigarettes? ____ Number per day ____ Did you smoke in the past?_____
Do you: Drink alcohol? _____ Drinks per week _____
Do you: Drink coffee? _____ Drinks per week _____
Other recreational drugs? _____
With whom do you live?_____
Do you exercise? How many times per week, and what do you do? _____
_____

Family history: Please list age at which the family member was diagnosed:

Heart problems_____
Stroke or paralysis_____
Blood clots_____
Jaundice or Liver problems_____
Kidney disease_____
Diabetes_____
High blood pressure_____
Genetic problems, birth defects_____
Thyroid problems_____
Alcoholism or drug dependency_____
Bleeding problems_____

Fibroids_____
Infertility_____
Polycystic ovarian syndrome_____
Cancer:
Breast cancer_____
Uterine cancer_____
Ovarian cancer_____
Cervical cancer_____
Colon cancer_____
Other:_____

Healthcare Maintenance (please write approximate date):

Last pap (over age 21): _____

History of abnormal paps: _____

Last mammogram (over age 40):_____

Last bone scan (DEXA) (over age 65): _____

Last colonoscopy (over age 50): _____

Last Tetanus-Diptheria booster vaccine:_____

Have you had your:

_____HPV vaccine (under age 26)

_____Pneumococcal vaccine (over age 65)

_____Shingles (Zooster) vaccine (over age 60)

Pharmacy you use: _____