

Medical History

Date _____ Name _____ Age _____ Date of birth _____
Primary care doctor name and address _____

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

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| <input type="checkbox"/> Genetic conditions or birth defects | <input type="checkbox"/> Alcoholism or drug dependency |
| <input type="checkbox"/> Heart Disease or heart murmur | <input type="checkbox"/> Frequent urinary tract infections |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Kidney infections |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Kidney stone |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lupus or fibromyalgia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Spine, hip or knee problems |
| <input type="checkbox"/> Frequent headaches/migraines | <input type="checkbox"/> Breast disease |
| <input type="checkbox"/> Gastrointestinal problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Unintentional, rapid weight loss or gain |
| <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Skin rashes |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Epilepsy/convulsions |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood transfusion |
| <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Problems with anesthetics |
| <input type="checkbox"/> Depression or anxiety | |
- Cancer: Uterus Breast Cervix Colon Ovary Other: _____

Medications (including over the counter and supplements):

Name	Dose	How often	Purpose

Drug Allergies:

Name	Reaction

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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? _____ Do you have painful cramps? ___ Yes ___ No

Number of pads/tampons on your heaviest day _____

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-Diphtheria booster vaccine: _____

Have you had your:

_____ HPV vaccine (under age 26)

_____ Pneumococcal vaccine (over age 65)

_____ Shingles (Zooster) vaccine (over age 60)