PATIENT HISTORY

Personal History of Past Illness

Major Illness	Yes (Date)	Major Illness	Yes (Date)
Anemia		Glaucoma	
Arthritis / Joint pain		Headaches (chronic only)	
Asthma		Heart Disease	
Back problems		Hepatitis/Yellow Jaundice/Liver Disease	
Blood Clots in lungs or legs		High Blood Pressure	
Blood Transfusions		High Cholesterol	
Bowel Problems		HIV/Aids	
Broken bones		Kidney Infection/Kidney Stones	
Cancer		Pneumonia/Lung Disease	
Cataracts		Reflux/Hiatal Hernia/Ulcers	
Chickenpox		Rheumatic Fever	
Collagen Vascular Disease (Lupus)		Seizures/Convulsions/Epilepsy	
Depression or Anxiety (circle)		Sexually Transmitted Disease	
Diabetes		Stroke	
Eating Disorders		Thyroid Disease	
Gallbladder Disease		Tuberculosis	
Other			

GYN History

Problem	Yes	No	Problem	Yes	No
Abnormal hair growth			Infertility		
Abnormal Bleeding			Ovarian Cyst		
Abnormal Pap Smear			Osteoporosis		
Breast Problems			Sexual Problems		
Cyst of Vulva			Sexually transmitted disease		
DES Exposure			Uterine Abnormality		
Endometriosis			Urinary Leakage		
Fibroid Uterus			Vaginal/Vulvar Infection		

Surgeries

Surgery	Yes	No	Date / Comments
Abdominal Surgery			
C-Section Delivery			
Dilation & Curettage (D & C)			
Hysterectomy			
Hysterectomy (out patient)			
Laparoscopy (out patient)			
Vaginal Surgery			
Bartholin Gland Surgery			
Other (Please List):			

Social History

Preferred Name:	PCP:	Occupation:
Number of people in household:	Single Married Widowed Divorced Separated Living w/partner	
Education (last grade completed):	Name of significant other:	
Children's Names:		
Seat Belt Use: None Frequently Occasionally Never		
Occupational Risk: None Biohazard Chemical Physical Labor		
How many days per week do you exercise:	How many packs of cigarettes per day do you smoke?	
How many times per week do you drink alcohol?		
Do you use any of the following? cocaine narcotics marijuana hallucinogens		