

MEDICAL HISTORY

(This Information is Confidential)

Name: _____ Age: _____ Date of Birth: _____ Date: _____

Are you Allergic to any medications? (If yes, which medications?) _____

Reason for Visit: _____ Occupation: _____

Menstrual History:

- First day of Last Menstrual Period: _____ Age first Period began? _____
- How Often do you menstruate? Every _____ days
- How long do your periods last? _____ Days. Regular Cycles? _____ YES _____ NO.
- Cramps: __NONE/ __Moderate/ __Severe.
- Menopausal: _____ YES _____ NO. Age of menopause: _____

Gynecologic History: Have you ever had any of the following? (Circle if yes)

Recurrent vaginal infections	Breast disease	Fibroids	Previous treatments? _____
Pain with intercourse	Frequency/ Painful urination	Infection of Pelvic organs PID	Difficulty holding urine
Concern about sexual function	Taken Hormone Replacement	Pelvic Pain	Blood in urine
Abnormal Pap smear	Mood changes/ feels irritable	Spotting in between periods	Breast cancer? How long? _____
Surgery on your female organ	Hot flashes/ problem sleeping	Missed periods	Unusual vaginal bleeding
Prolonged Bleeding	Endometriosis	Infertility? __ No. of years	

Date of Last Pap Smear? _____ **Date of Last Mammogram?** _____

- Are you Sexually active? __Y__N. If not, since when? _____. Do you have more than one partner? __Y__N
- How long have you been with your current sexual partner? _____ Is your partner __M__ F __Both.
- Age at first intercourse? _____. Number of sexual partners in your life? _____
- What is your current method of contraception? _____ Are you satisfied with this method? _____
- What methods have you tried in the past? _____ Are you trying to get pregnant? __Y__N
- Do you plan pregnancy in the future? __Y__N.

Pregnancy History: List all Pregnancies in order (including abortions, miscarriages, ectopics)

NO.	Year	Weeks/ Months	Sex	Weight	Complications

Family History: Have your parents, brothers, sisters ever had any one of the following? (Circle if yes)

Heart Problems	Diabetes	Kidney disease	Liver disease
Stroke/ paralysis	High Blood pressure	Asthma/ tuberculosis	Drug dependency
Blood clots	Genetic conditions	Birth Defects	Alcoholism
Jaundice/ hepatitis	Thyroid problems	Uterine/ ovarian cancer	Cervical cancer

