Name ___________________________Date of Birth _______Todays Date ________

Past Medical History ©2002

(Please provide details of your personal medical history, & indicate Dates & Treatment)

Asthma
Cancer
Diabetes
Hypothyroid or Thyroid Dysfunction
Heart Disease / Stroke
Heart Murmur / Valve Prolapse
Deep Venous Thrombosis/ Pulmonary Emboli
Varicosities / Phlebitis

Epilepsy / Seizures
Tuberculosis and/or PPD +
Kidney Disease
Liver Disease / Hepatitis
Anxiety / Depression
Abuse
Mental Health Problem
Stomach Ulcers
Major Accidents
History of Blood Transfusion
Rh Sensitized / Rh Isoimmunization
Sexually Transmitted Disease
Herpes
Gonorrhea / Chlamydia
HIV / AIDS or Syphilis
Human Papilloma Virus / HPV
Abnormal Pap smear
Genital Warts
Endometriosis
Incontinence
Infertility / PCOS
Abnormal Uterus / Fibroids
Hypertension

List all prior SURGERIES, major and minor:

List all hospital stays:

Tobacco use / Cigarettes:
Age started smoking:
Age stopped smoking:
Number of cigarettes/day

Alcohol Use:
Number of Drinks / Week

Do you use or have you used Recreational Drugs?
If yes, what drugs and when?
____
____

List ALL presently used MEDICATIONS along with their DOSAGE and FREQUENCY (including over the counter meds): ____
____
____

List ALL medications to which you are ALLERGIC: ____
____

Past pregnancies

Year of Delivery	Length of Labor	Birth Weight	Type of Delivery	Male/Female & Name(s)	Place of Delivery	Comments / Complications

Please list all miscarriages (years occurred and # of weeks pregnant):
____
____

Age at first period ______Date last menstrual period began _________ how long did it last?
____

Flow of periods are: normal ______heavier ______lighter ______ Are your periods regular?
____

How often? ______Do you have pain with periods? _____Does pain require medication?
____

If so what medications? _________________________ Date of last pap smear/result?
____

Present type of birth control used _________________If oral contraception, name of pill___________

Family History

Breast Cancer___________ If yes, what relationship? ______________________________Age @ diagnosis_______
Ovarian Cancer__________ If yes, what relationship? _____________________________ Age @ diagnosis_______
Colon Cancer ___________ If yes, what relationship? ______________________________Age @ diagnosis_______
Other
____
______