LINDA I. SODOMA DO
MEDICAL HISTORY FORM

NAME_____ BIRTHDATE_____

DATE_____SSN_____

I. What brings you to see the doctor?_____

_____

_____

II. **Menstrual History**: Age when 1st period started_____
Are your cycles regular? **Yes No** Are your periods: **Regular Irregular**
How many days do you bleed? _____ How long are your cycles (average is 28-30 days_____
How many days of heavy flow?_____Do you need double protection? **Yes No**
Do you have bleeding between periods? **Yes No** Are your periods painful? **Yes No**
How many days of pain per cycle? _____

III. **Obstetric History** Number of: Pregnancies _____Miscarriages_____
Elective Terminations_____ Living Children_____

YEAR	MONTHS PREGNANT	COMPLICATIONS	BIRTH WEIGHT	SEX	COMMENTS

IV. **Gynecologic History:**
Date of last pap smear (mo/yr) _____ Have you ever had and abnormal pap? **Yes No**
Have you ever had an infection of your uterus, tubes or ovaries (PID) **Yes No**
Prior Gynecological Surgeries _____

_____

_____

Have you ever had Chlamydia, gonorrhea, herpes, genital warts or any other sexually transmitted disease? **Yes No** Do you have frequent vaginal infections/abnormal discharge? **Yes No**
Do you have pain/bleeding with intercourse? **Yes No**
Do you have more than one sexual partner? **Yes No**
When was your last mammogram?_____ Was it normal?_____
Any other significant past gynecological history?_____

_____

_____

V. **Contraception:** Current Method (circle)

None Condoms Tubal Ligation Pills IUD Foam Norplant

Inserts Rhythm Vasectomy Diaphragm Withdrawal

VI. Family History

Relationship	**Age or Age at Death**	**Illnesses or Cause of Death**
Mother		
Father		
Sister(s)		
Brother(s)		

Any family history of (circle all that apply) **Diabetes Heart Disease High Cholesterol Alzheimer's**

Strokes Breast Cancer Uterine Cancer Ovarian Cancer Other Cancers Osteoporosis

VII. General Medical History

Do you have any ongoing medical problems?_____

_____

Prior Non-gynecological surgeries?_____

_____

List current medications:_____

_____

List vitamins and herbal supplements including doses_____

_____

Allergies to medications_____

_____

List childhood illnesses_____

_____

Has your weight changed in the last year? Yes No If so, how much? _____

Do you have problems with the following?

Head, eyes, ears, nose & throat (i.e. convulsions, visual difficulties, seizures,etc)	YES	NO
Breathing (i.e. cough, asthma, TB, valley fever	YES	NO
Hypertension	YES	NO
Diabetes	YES	NO
Heart Disease (heart attack, palpitations, chest pain, murmur)	YES	NO
Breast Discharge (milky, watery, bloody), Pain or Breast Lumps	YES	NO
Nausea, Vomiting, Diarrhea, Blood in Stool, Hepatitis	YES	NO
Kidney or Bladder Infection, Stones, Blood in Urine	YES	NO
Skin Problems (including excessive hair, hair loss, acne)	YES	NO
Emotional Problem (Depression, suicide attempts, anxiety)	YES	NO

Please explain any Yes answer_____

_____

VIII. Social History

Do you smoke? **Yes No** If so, how long have you smoked? _____Years Cigarettes/Day_____
Did you smoke previously? _____Years When did you quit?_____
Do you drink alcohol? **Yes No** What and how much?_____
Do you use street drugs? **Yes No** Identify drugs_____
Do you exercise? **Yes No** What type and how often?_____
Do you eat a balanced diet? **Yes No** Occupation_____