OB/GYNE
Associates of Lake Forest, Ltd.

Patient Medical History Form

Today's Date:

Name:	**Date of Birth:**

NAME OF CHILD	DATE OF DELIVERY MM/DD/YYYY	HOW MANY WEEKS AT DELIVERY	C-SEC OR VAG	M/F & WEIGHT	TYPE OF ANESTHESIA	HOSPITAL	COMPLICATIONS
#1							
#2							
#3							
#4							
#5							
#6							

History of miscarriages? ☐ Yes ☐ No **# of miscarriages _____ Was a D&C required? (If yes) Date: _____**
History of abortions? ☐ Yes ☐ No **# of abortions _____**

GYNECOLOGICAL HISTORY

Age of first period? **Date of last menstrual period?**

How often do you get your period? (i.e. every 2 weeks, every month?)

How many days does your period last?

How many pads and/or tampons do you use on an average day?

Cramps/pain? **What medications do you use?**

Contraceptive method currently being used? ☐ Patch ☐ Vasectomy ☐ Ring ☐ Depo ☐ Condoms ☐ Natural Family Planning ☐ Rhythm ☐ Withdrawal ☐ IUD (type) _____ ☐ Pill (type)_____

Sexually Transmitted Infections? ☐ Herpes ☐ Chlamydia ☐ Gonorrhea ☐ HPV **Was this treated?** Yes ☐ No ☐

Sexual Dysfunction problems?

SOCIAL HISTORY

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner ☐ Same Sex Partner

Age of first intercourse? _____ # of partners _____

Currently sexually active? ☐ Yes ☐ No with Male ☐ with Female ☐ with Both ☐

Domestic abuse? ☐ Yes ☐ No

Sexual abuse? ☐ Yes ☐ No

Smoking? ☐ Yes ☐ No **# of packs per day ____ # of years used ____**

Alcohol? ☐ Yes ☐ No **# of drinks per day ____ # of drinks per week ____**

Substance Abuse? ☐ Yes ☐ No

Have you received the COVID-19 vaccination? ☐ Yes ☐ No
If yes, which vaccine: ☐ Moderna ☐ Pfizer ☐ Johnson & Johnson
Please list dates: 1st dose _____ 2nd dose _____

Have you received a flu shot in the last 12 months? ☐ Yes ☐ No
If yes, please list date: _____

	IF YOU CHECK YES TO ANY OF THE FOLLOWING, PLEASE PROVIDE THE DATE
Appendectomy	☐ Yes ☐ No Date:
Gall Bladder removal	☐ Yes ☐ No Date:
Breast surgery ☐ Yes ☐ No	If so, please check the following and was result cancerous of not: Biopsy: ☐ Yes ☐ No Right Breast ☐ Left Breast ☐ Date : _____ Mastectomy: ☐ Yes ☐ No Right Breast ☐ Left Breast ☐ Date: _____ Lumpectomy: ☐ Yes ☐ No Right Breast ☐ Left Breast ☐ Date: _____
Total Abdominal Hysterectomy	☐ Yes ☐ No (see below for ovaries) Date: _____
Vaginal Hysterectomy	☐ Yes ☐ No (see below for ovaries) Date: _____
Laparoscopy	☐ Yes ☐ No Date: Ovarian cysts: ☐ Yes ☐ No Right ☐ Left ☐ Both ☐ Endometriosis: ☐ Yes ☐ No
Removal of ovaries	☐ Yes ☐ No Right ☐ Left ☐ Both ☐ Date:
Cervical cryotherapy (freeze)	☐ Yes ☐ No Date:
Cervical LEEP cone	☐ Yes ☐ No Date:
Cervical cone biopsy	☐ Yes ☐ No Date:
Any other surgeries	☐ Yes ☐ No If yes, please list below
#1	Date:
#2	Date:
#3	Date:

FAMILY HISTORY					
Breast cancer	☐ Yes	☐ No	☐ Maternal	☐ Paternal	Who?
Age of diagnosis?	Still alive?	☐ Yes	☐ No	Age of death	
Ovarian cancer	☐ Yes	☐ No	☐ Maternal	☐ Paternal	Who?
Age of diagnosis?	Still alive?	☐ Yes	☐ No	Age of death	
Colon cancer	☐ Yes	☐ No	☐ Maternal	☐ Paternal	Who?
Age of diagnosis?	Still alive?	☐ Yes	☐ No	Age of death?	
Heart disease	☐ Yes	☐ No	☐ Maternal	☐ Paternal	Who?
Age of diagnosis?	Still alive?	☐ Yes	☐ No	Age of death?	
Diabetes	☐ Yes	☐ No	☐ Maternal	☐ Paternal	Who?
Age of diagnosis?	Still alive?	☐ Yes	☐ No	Age of death?	

ANY ALLERGIES (PLEASE LIST BELOW)

MEDICAL HISTORY	(PLEASE CHECK ALL THAT APPLY TO YOU)
Cardiovascular:	☐ Heart Attack ☐ Artery disease ☐ Angina ☐ CHF ☐ High BP ☐ High Cholesterol
Endocrine:	☐ Diabetes ☐ Low Thyroid ☐ High Thyroid
Respiratory:	☐ Asthma ☐ Allergies
Immune:	☐ HIV+
Gastrointestinal:	☐ Reflux ☐ Hepatitis ☐ Irritable Bowel ☐ Colitis
Genitourinary:	☐ Stones ☐ Kidney infection ☐ Chronic UTI
Musculoskeletal:	☐ Arthritis ☐ Osteoporosis ☐ Osteopenia
Psychiatric:	☐ Depression ☐ Anxiety ☐ PMS ☐ Bipolar ☐ Post-partum depression
Neurological:	☐ Stroke ☐ Mini-stroke ☐ M.S. ☐ Seizures ☐ Migraines
Rheumatology:	☐ Fibromyalgia ☐ Lupus
Hematology/oncology:	☐ Factor 5 ☐ MTHFR ☐ Blood clots/thrombophilia

PLEASE LIST ANY MEDICATIONS AND HERBAL SUPPLEMENTS THAT YOU TAKE	DOSE	HOW FREQUENTLY (PLEASE LIST HERBAL SUPPLEMENTS ALSO)

Name and location of pharmacy that you use: _____

Phone number of pharmacy: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1.) Little interest or pleasure in doing things	0	1	2	3
2.) Feeling down, depressed or hopeless	0	1	2	3

Score: _____

M.A. Initials: _____

REVIEW OF SYSTEMS

(Please check yes or no for ALL symptoms)

Systemic Symptoms:

Weight change	□ Yes	□ No
Chills	□ Yes	□ No
Fever	□ Yes	□ No
Night sweats	□ Yes	□ No
Hot flashes	□ Yes	□ No
Difficulty sleeping	□ Yes	□ No
Feeling tired	□ Yes	□ No
Easy bruising	□ Yes	□ No

Head and Neck Symptoms:

Headache	□ Yes	□ No
Hoarseness	□ Yes	□ No
Throat pain	□ Yes	□ No
Sense of mass in throat with swallowing	□ Yes	□ No

Pulmonary Symptoms:

Shortness of breath	□ Yes	□ No
Cough	□ Yes	□ No
Snoring or stopping breathing in sleep (apnea)	□ Yes	□ No

Cardiovascular Symptoms:

Chest pain or discomfort	□ Yes	□ No
Fast heart rate	□ Yes	□ No
Palpitations or irregular heart rate	□ Yes	□ No
Syncope	□ Yes	□ No

Gastrointestinal Symptoms:

Change in appetite	□ Yes	□ No
Heartburn	□ Yes	□ No
Nausea	□ Yes	□ No
Vomiting	□ Yes	□ No
Abdominal pain	□ Yes	□ No
Increase in abdominal girth	□ Yes	□ No
Early satiety (feeling full)	□ Yes	□ No
Constipation	□ Yes	□ No
Diarrhea	□ Yes	□ No
Black/Bloody stools	□ Yes	□ No

Genitourinary Symptoms:

Dysuria (pain with urination)	□ Yes	□ No
Increased urinary frequency	□ Yes	□ No
Hematuria	□ Yes	□ No
Incontinence	□ Yes	□ No
Incomplete emptying	□ Yes	□ No
Genital pain	□ Yes	□ No
Genital lesion	□ Yes	□ No

Gynecologic Symptoms:

Irregular cycle intervals	□ Yes	□ No
Bleeding between periods	□ Yes	□ No
Pelvic pain	□ Yes	□ No
Bloating	□ Yes	□ No
Vaginal discharge	□ Yes	□ No
Vaginal itching	□ Yes	□ No

Breast Symptoms:

Breast pain	□ Yes	□ No
Nipple discharge	□ Yes	□ No
Breast lump/mass	□ Yes	□ No

Endocrine Symptoms:

Excessive sweating	□ Yes	□ No
Excessive thirst	□ Yes	□ No
Libido/Sex drive change	□ Yes	□ No

Psychological Symptoms:

Anxiety	□ Yes	□ No
Depression	□ Yes	□ No
Anger	□ Yes	□ No
Alcohol/Substance abuse	□ Yes	□ No
Irritability prior to menses	□ Yes	□ No
Emotional lability	□ Yes	□ No

Skin and Hair Symptoms:

Pruritus (itching)	□ Yes	□ No
Skin lesions	□ Yes	□ No
Hair loss	□ Yes	□ No
Rash	□ Yes	□ No