Martin, Lee & Page OBGYN
PATIENT MEDICAL HISTORY

Name: _____ Appointment Date: _____

Birthdate: _____ Age: _____ Physician: _____

Visit Reason: ❑ Routine ❑ Pregnancy ❑ Problem Describe Any Problems: _____

This section relates to medical conditions you have experienced BOTH currently AND in the PAST.
If you have EVER been treated for any of these conditions, please check "yes".

Medical Condition	Yes	No	Medical Condition	Yes	No	Medical Condition	Yes	No
Abnormal Pap Smear			Anemia			Arthritis / Joint Pain		
Abnormal Uterine Bleeding			Blood Transfusions			Bone Fractures		
Fibroid Tumors			Heart Disease			Osteopenia		
Infertility			Heart Murmur			Osteoporosis		
Chlamydia			High Blood Pressure					
Gonorrhea			High Cholesterol			Chicken Pox		
Herpes Simplex Virus - HSV			Phlebitis / DVT			Measles		
Human Papilloma Virus-HPV			Sickle Cell Disease or Trait			Mumps		
Sexually Transmitted Disease			Stroke			Rheumatic Fever		
Breast Cancer			Diabetes					
Cervical Cancer			Hypoglycemia			Anxiety		
Ovarian Cancer			Autoimmune Disease			Depression		
Uterine Cancer			Thyroid Disease			Mood Disorders		
Other Cancer (List)						Neurological Disorder		
			Abnormal Stools			Tay-Sachs Disease		
			Bowel Incontinence					
Kidney Infections			Colon Cancer			Glaucoma		
Kidney Stones			Irritable Bowel Syndrome					
Urinary Disease			Ulcers			Asthma		
-- Incontinence						Chronic Lung Disease		
-- Overactive Bladder			Hepatitis / Jaundice			Pneumonia		
Urinary Tract Infection			Liver Disease			Tuberculosis - TB		

Immunization History

Immunization	Last Date Received
Influenza Vaccine (Flu Shot)	
Pneumonia Vaccine	
Tetanus	
Gardasil (HPV)	
Other:	

Screening Examinations History

Examination Type	Date	Results
Bone Density Screening		
Colonoscopy / Sigmoidoscopy		
Mammogram		
Pap Smear		
TB Skin Test		
Other Lab Tests:		

Past Injuries and Illnesses

Type	Date

Prior Surgeries, Hospitalizations, and Office Procedures

Type	Date

Martin, Lee & Page OBGYN
PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

MEDICATIONS TAKEN – Include Over the Counter, Herbal & Natural Remedies, Vitamins, and Supplements

Medication Name	Strength mg, mcg, IU, g, etc.	How Much / Many Taken at a Time? (number of pills, mls, tsp, etc.)	How Often Do You Take the Medication?	Prescriber	Check here if Not a Prescription

List any additional medications on a separate sheet and bring it with you to your appointment.

ALLERGIES

❑ Penicillins	❑NSAIDS (like Naproxen)	List Others:
❑ Sulfa (Sulfonomides)	❑ Opioid Analgesics	
❑ Tetracyclines	❑ Iodine	
❑ Fluoroquinolones (like Cipro)	(including Shellfish)	
❑ Latex	❑ Seasonal	

FAMILY HISTORY – BLOOD RELATIVE MEDICAL HISTORY

Condition	Relationship of Relative(s) Diagnosed with Condition M-Mother, F-Father, S-Sister, B-Brother, D-Daughter, N-Son MM-Maternal Grandmother, MF-Maternal Grandfather PM-Paternal Grandmother, PF-Paternal Grandfather, O-Other											Alive or Deceased	Age at Death
	M	F	S	B	D	N	MM	MF	PM	PF	O		
Breast Cancer	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
Ovarian Cancer	❑		❑		❑		❑		❑		❑		
Uterine Cancer	❑		❑		❑		❑		❑		❑		
Colon Cancer	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
Other Cancer:	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
Chronic Lung Disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
Depression/Anxiety	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
Endometriosis	❑		❑		❑		❑		❑		❑		
Glaucoma	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
Heart Disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
Hemophilia	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
Hepatitis / Liver Disease	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
High Blood Pressure	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
Sickle Cell Disease/Trait	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
Stroke	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
Other:	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		
Other:	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑		

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PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

REPRODUCTIVE HISTORY

Age When You Had Your First Period: _____

Number of Days in Menstrual Cycle: _____
(From First Day of Period to First Day of Next Period)

Number of Days Your Period Lasts: _____

Flow: ❑ Light ❑Medium ❑ Heavy _____

Number of Tampons Used per Day: _____

Number of Pads Used Per Day: _____

DATE OF LAST MENSTRUAL PERIOD: _____

About Your Period…

Do You Have Bleeding Between Periods?: ❑ Yes ❑ No

Do You Have Cramping?: ❑ Yes ❑ No

Do You Have Clots?: ❑ Yes ❑ No

Do You Have Pain?: ❑ Yes ❑ No

Menopause

Are You in Menopause?: ❑ Yes ❑ No

If Yes, At What Age Did You Begin Menopause?

Have You Had a Hysterectomy?: ❑ Yes ❑ No

If Yes, What is the Date?:

Are You Taking Hormone Replacements? ❑ Yes ❑ No

If Yes, Specify:

Birth Control Method

❑ None ❑ Birth Control Pill

Name of Medication:

❑ Condom ❑ DepoProvera

❑ Contraceptive Foam/Jelly ❑ IUD - _____

❑ Diaphragm ❑ Nuvaring

❑ Natural / Rhythm Method ❑ Birth Control Patch

❑ Withdrawal ❑ Tubal Ligation

❑ Vascectomy ❑ Other:

Pregnancy and Childbirth

Have You Ever Been Pregnant?: ❑ Yes ❑ No

If Yes, How Many Times?:

How Many Children Do You Have?:

How Many Were Full Term?:

How Many were Premature?:

Have You Ever Had a Miscarriage?: ❑ Yes ❑ No

If Yes, How Many Times?:

Have You Ever Had an Abortion?: ❑ Yes ❑ No

If Yes, How Many Times?:

Pregnancy Review

Complete this Section Regarding Each of Your Pregnancies, including Miscarriages or Abortions

Date	Weeks at Time of Delivery	Hours in Labor	Baby's Weight	Baby's Sex M/F	Type of Delivery Vaginal / C-section	Anesthesia (Epidural, General, Other)	Preterm Labor? Yes/No	Comments / Complications	Location

Questions You Want to Address with the Physician? (Reminder for Your First Visit)

Martin, Lee & Page OBGYN
PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS - Continued

This Section is Related to Your **Current Medical Status – Check All That Apply NOW**

Do Not Include Past History of Symptom or Illness if the Condition is not Currently Affecting You

Medical Condition	Yes ☑	Notes	Medical Condition	Yes ☑	Notes
Constitutional			***Respiratory***		
Weight Loss	❑		Cough	❑	
Weight Gain	❑		Wheezing	❑	
Fever	❑		Shortness of Breath	❑	
Fatigue	❑		Coughing with Blood	❑	
Night Sweats	❑		Smoking	❑	
Hot Flashes	❑				
			Gastrointestinal		
HENT			Nausea	❑	
Headaches	❑		Vomiting	❑	
Dizziness	❑		Diarrhea	❑	
Sinus Pain	❑		Constipation	❑	
Sinus Congestion	❑		Abdominal Pain	❑	
Nose Bleeds	❑		Bloody / Black Stool	❑	
Oral Ulcers	❑		Hemorrhoids	❑	
Sore Throat	❑		Jaundice (Yellowed Skin)	❑	
Neck Stiffness	❑		Heartburn	❑	
Thyroid Mass	❑		Loss of Appetite	❑	
Breast			***Genitourinary***		
Lump(s)	❑		Urinate with Urgency	❑	
Tenderness	❑		Urinate Frequently	❑	
Pain	❑		Painful Urination	❑	
Swelling	❑		Urinate After Bedtime	❑	
Discharge	❑		Urine Incontinence	❑	
Abnormal Changes (Breast)	❑		Difficult Urination	❑	
			Incomplete Urination	❑	
Cardiovascular			Blood in Urine	❑	
Chest Pain	❑		Decreased Sex Drive	❑	
Irregular Heartbeat	❑		Painful Intercourse	❑	
Rapid Heart Rate	❑		Possible Pregnancy	❑	
Fainting	❑		+ Home Pregnancy Test	❑	
Dizziness	❑		Genital Sores	❑	
Varicose Veins	❑		Irregular Periods	❑	
Leg / Foot Swelling	❑		Vaginal Discharge	❑	
Arm / Hand Swelling	❑		Vaginal Itching/Burning	❑	
Blood Clots (Legs)	❑		Vaginal Dryness	❑	
			Premenstrual Syndrome (PMS)	❑	
			Do you still have periods?	❑	

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Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS - Continued

This Section is Related to Your **Current Medical Status – Check All That Apply NOW**

Do Not Include Past History of Symptom or Illness if the Condition is not Currently Affecting You

Medical Condition	Yes ☑	Notes	Medical Condition	Yes ☑	Notes
Skin			***Endocrine***		
Rashes	❑		Loss of Hair	❑	
Itching	❑		Difficulty Tolerating Cold	❑	
Skin Dryness	❑		Difficulty Tolerating Heat	❑	
Skin Lesions	❑		Excessive Thirst	❑	
Changes in Moles/Lesions	❑				
Acne	❑		***Mental Status***		
Nail Fungus	❑		Anxiety	❑	
Excessive Hair Growth	❑		Depression	❑	
			Impulsive Behavior	❑	
Neurological			Excessive Anger	❑	
Muscle Weakness	❑		Confusion	❑	
Numbness / Tingling	❑		Mood Swings	❑	
Difficulty Concentrating	❑		Compulsive Behavior	❑	
Memory Difficulties	❑		Difficulty Sleeping	❑	
Speech Difficulties	❑		Suicidal Thoughts	❑	
Seizures	❑		Emotional Abuse	❑	
Loss of Balance	❑		Physical Abuse	❑	
			Sexual Abuse	❑	
Musculoskeletal					
Joint Pain / Swelling	❑		***Hematologic / Lymphatic***		
Muscle Pain	❑		Craving for Ice	❑	
Back Pain	❑		Easy/Frequent Bruising	❑	
			Bleeding Difficult to Stop	❑	
			Enlarged Lymph Nodes	❑	

SOCIAL HISTORY

The following social history questions are suggested by the American College of Obstetrics and Gynecology for appropriate evaluation. If you are uncomfortable providing answers to any of these questions, please speak with your doctor or nurse.

How Often Do You Exercise?: ❑ None ❑ 1-3 Times Per Week ❑ 4 or More Times Per Week

Are You Sexually Active?: ❑ Yes ❑ No Sexual Preference: ❑ Men ❑ Women ❑ Both

Frequency of Sexual Activity: _____ Per Week First Intercourse at Age: _____

Current New Sexual Partner?: ❑ Yes ❑ No

Number of Sexual Partners Lifetime?: ❑ One ❑ Less Than 5 ❑ More Than 5

Tobacco Smoker?: ❑ Yes ❑ No Packs/Day _____ Age Started _____

❑ Never Smoked Age Stopped _____

Alcohol Use?: ❑ Yes ❑ No Drinks/Day _____ Age Started _____

❑ Never Drank Drinks/Week _____ Age Stopped _____

Drug Use?: ❑ Yes ❑ No Frequency: _____ per ❑ Day ❑ Week ❑Month

Type of Drug: _____

History of Abuse?: ❑ Yes ❑ No ❑ Emotional ❑ Physical ❑ Sexual