MEDICAL HISTORY

DATE _____ **NAME** _____ **AGE** _____

LAST MENSTRUAL PERIOD _____ **LAST PAP** _____ **LAST MAMMOGRAM** _____

CONTRACEPTION _____ **CURRENT MEDICATIONS** _____

CURRENT PROBLEM _____

INSTRUCTIONS: CHECK ALL POSITIVE FINDINGS IN THE COLUMN BELOW/GIVE DETAILS IF POSITIVE

GYNECOLOGICAL HISTORY

MENSTRUAL: AGE AT FIRST PERIOD _____ **LENGTH OF CYCLE** _____ **DURATION** _____

_____ **PELVIC PAIN** _____ **INTERMENSTRUAL BLEEDING** _____ **POSTCOITAL BLEEDING**
_____ **VAGINAL DISCHARGE** _____ **URINARY INCONTINENCE** _____ **INFERTILITY**
_____ **ABNORMAL PAP** _____ **SEXUAL PROBLEMS** _____ **ABNORMAL BLEEDING**
_____ **VAGINAL DISCOMFORT** _____ **VAGINAL PROLAPSE** _____ **HOT FLASHES**

PAST MEDICAL HISTORY

_____ **HIGH BLOOD PRESSURE** _____ **DEPRESSION/ ANXIETY** _____ **DIABETES**
_____ **HEART DISEASE** _____ **CONSTIPATION** _____ **UTI**
_____ **ASTHMA** _____ **ANEMIA** _____ **HEADACHES**
_____ **PCOS** _____ **STD**

FAMILY HISTORY

_____ **BREAST CANCER** _____ **HEART DISEASE** _____ **DIABETES** _____ **GENETIC**

OTHER _____

DRUG ALLERGIES _____

SOCIAL: **TOBACCO** _____ **ALCOHOL** _____ **DRUGS** _____

OBSTETRICAL HISTORY: NUMBER OF CHILDREN LIVING			**DEAD**		**MISCARRIAGE**		
MO/YR	**HOSPITAL**	**COMPLICATIONS**	**ANESTHESIA**	**LENGTH OF PREGNANCY**	**LENGTH OF LABOR**	**WT**	**SEX**

OPERATIONS AND /OR HOSPITALIZATIONS						
YEAR	**AGE**	**TYPE**	**DIAGNOSIS**	**COMPLICATION**	**HOSPITAL**	**DOCTOR**