Wittgrove Brown
OBSTETRICS / GYNECOLOGY

MEDICAL HISTORY FORM

PLEASE PRINT

Date _____

Name _____ Age _____

A. MENSTRUAL HISTORY

Age periods started _____ Are they regular? Age of menopause

Explain _____

1st day of last period _____ Duration _____

Cycle length (start-to-start) _____ Cramps? _____

B. GYNECOLOGIC HISTORY

Current Birth control method _____ Date of last Pap Smear? _____

Have you ever had/used? If so, when?

Birth Control Pills _____ IUD _____

Cervix (Cauterized/Frozen) _____ D&C _____

Tubal Infection (PID) _____ Herpes _____

Sexually Transmitted Infection (STD) _____ Abnormal Pap Smear _____

C. PREGNANCY HISTORY

Total number of Pregnancies _____ # abortions _____ # miscarriages _____

	Year	Sex	Weight	Vaginal/C-Section	Complications/Comments
1.					
2.					
3.					
4.					
5.					

D. PAST MEDICAL HISTORY

Serious Illnesses (childhood & adult)? _____

Surgeries/Year Performed, (e.g., tonsils, appendix, etc) _____

1. _____
2. _____
3. _____

E. MEDICATIONS

List Allergy & Reaction _____

List your Medications & Dosage

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

F. SOCIAL HISTORY

Do you smoke? _____ How much per week? _____

Do you use alcohol? _____ How much per week? _____

G. FAMILY HISTORY (please specify relative)

Cancer _____ Suicide/mental Illness _____

Heart Disease _____ Tuberculosis Exposure _____

Stroke _____ Diabetes _____

High Blood Pressure _____