Medical Information

Name: _____ D.O.B. _____

Personal History

Have you had...	Yes	No	Don't Know
1. High Blood Pressure	☐	☐	☐
2. Diabetes	☐	☐	☐
3. Thyroid Disease	☐	☐	☐
4. Anemia	☐	☐	☐
5. Cancer (Female, Skin)	☐	☐	☐
6. Genital Warts/HPV	☐	☐	☐
7. Gardasil Vaccination	☐	☐	☐
8. Yeast Infections	☐	☐	☐
9. Bladder Infections	☐	☐	☐
10. Gonorrhea or Syphilis	☐	☐	☐
11. Chlamydia	☐	☐	☐
12. Heart Disease	☐	☐	☐
13. Heart Murmur	☐	☐	☐
14. Chest Pain	☐	☐	☐
15. Gall Bladder Disease	☐	☐	☐
16. Stomach Trouble/Ulcer	☐	☐	☐
17. Rectal Bleeding	☐	☐	☐
18. Kidney Infection	☐	☐	☐
19. Hepatitis	☐	☐	☐
20. Herpes	☐	☐	☐
21. Sleep Problems	☐	☐	☐
22. Migraine Headaches	☐	☐	☐
23. Epilepsy (convulsions)	☐	☐	☐
24. Nervous Breakdown	☐	☐	☐
25. Breast Disease	☐	☐	☐
26. German Measles	☐	☐	☐
27. Pneumonia	☐	☐	☐
28. Tuberculosis	☐	☐	☐
29. Rheumatic Fever	☐	☐	☐
30. Thrombophlebitis	☐	☐	☐
31. Varicose Veins	☐	☐	☐
32. Arthritis	☐	☐	☐
33. Mammogram	☐	☐	☐
34. Chicken Pox/Shingles	☐	☐	☐
35. Asthma	☐	☐	☐

Gynecologic History

Menses

Age of Onset _____

Regular? ☐ Yes ☐ No

Cycle Length _____ days

Duration of Flow _____ days

Flow ☐ Light ☐ Medium ☐ Heavy

Pain or Cramps ☐ Yes ☐ No

Treatment of Cramps _____

Date of First Day of Last Period _____

Date of Last Pap Smear _____

Previous Abnormal Pap Smear? ☐ Yes ☐ No

Contraceptive Method Now and Previous Methods w/Dates

Birth Control Pills _____

Diaphragm _____

Intrauterine Device _____

Do you Breast Self-Exam? ☐ Yes ☐ No

Pregnancy History (include terminations and miscarriages)

Year	Baby's Weight	Sex	Type of Delivery	Complications
____	_____	____	_____	_____
____	_____	____	_____	_____
____	_____	____	_____	_____
____	_____	____	_____	_____
____	_____	____	_____	_____
____	_____	____	_____	_____

Height _____

Weight Now _____

Weight One Year Ago _____

Highest Weight (excluding Pregnancy) _____