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MEDICAL HISTORY FORM

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NAME _____ DATE OF BIRTH ____/____/____
LAST FIRST MI

REASON FOR VISIT: _____

PAST MEDICAL & FAMILY HISTORY

PLEASE CHECK & SPECIFY IF YOU OR YOUR CLOSE RELATIVES (FAM) HAD ANY OF THE FOLLOWING CONDITIONS

	SELF	FAM		SELF	FAM
STROKE	☐	☐	ANEMIA / BLOOD DISORDER	☐	☐
HEADACHES / MIGRAINE	☐		BLOOD TRANSFUSIONS	☐	
HEART DISEASE	☐	☐	THROMBOSIS / CLOTS IN VEINS	☐	☐
HIGH BLOOD PRESSURE	☐	☐	THYROID DISEASE	☐	☐
HIGH CHOLESTEROL	☐	☐	BREAST CANCER	☐	☐
ASTHMA	☐	☐	OVARIAN CANCER	☐	☐
DIABETES	☐	☐	UTERINE CANCER	☐	☐
WEIGHT LOSS / GAIN	☐		CERVICAL CANCER	☐	☐
LIVER DISEASE / HEPATITIS	☐	☐	COLON CANCER	☐	☐
REFLUX / PEPTIC ULCER	☐	☐	CANCER (OTHER)	☐	☐
BOWEL DISEASE	☐	☐	EPILEPSY / SEIZURES	☐	☐
KIDNEY / BLADDER DISEASE	☐	☐	ANXIETY / DEPRESSION	☐	
GALLBLADDER DISEASE	☐	☐	SLEEP PROBLEMS	☐	
ARTHRITIS / JOINT PAIN	☐	☐			

SURGERY / HOSPITAL ADMISSIONS

LIST ALL OPERATIONS AND/OR SERIOUS ILLNESSES WHICH REQUIRED HOSPITALIZATION (EXCLUDING PREGNANCY)

YEAR	SURGERY / REASON FOR ADMISSION	YEAR	SURGERY / REASON FOR ADMISSION

MEDICATIONS

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDING OVER-THE-COUNTER)

ALLERGIES to MEDICATIONS or LATEX

SOCIAL HISTORY

PLEASE CHECK ALL THAT APPLY TO YOU

Y ☐ N ☐ **SMOKING** # ____ CIG ☐ PACKS ☐ *PER* DAY ☐ WEEK ☐

Y ☐ N ☐ **ALCOHOL** # ____ DRINKS *PER* DAY ☐ WEEK ☐ MONTH ☐

Y ☐ N ☐ **COFFEE** # ____ CUPS *PER* DAY ☐ WEEK ☐

Y ☐ N ☐ **DRUGS** _____
SPECIFY

PLEASE COMPLETE BOTH SIDES OF THIS FORM

MENSTRUAL HISTORY AGE AT FIRST PERIOD? IF MENSTRUATING - DATE OF LAST PERIOD (1st day) ____/____/____

PERIODS ARE: ☐ REGULAR ☐ SOMEWHAT IRREGULAR ☐ COMPLETELY IRREGULAR

PERIOD INTERVAL (1st day to 1st day) - NUMBER OF DAYS DURATION OF BLEEDING FROM TO DAYS

BLEEDING (SPOTTING) BETWEEN PERIODS Y N PAINFUL PERIODS Y N

ANY PREMENSTRUAL SYMPTOMS LIKE IRRITABILITY, DEPRESSION, ANXIETY, BREAST PAIN, BLOATING? Y N

TIME LOST FROM SCHOOL / WORK BECAUSE OF PERIODS? Y N

SEXUAL HISTORY ARE YOU SEXUALLY ACTIVE? Y N PAIN / BLEEDING WITH INTERCOURSE Y N

DO YOU HAVE ANY QUESTIONS CONCERNING SEXUALITY?

OBSTETRICAL HISTORY PLEASE FILL IN ALL THAT APPLY

NUMBER OF ALL PREGNANCIES	NUMBER OF LIVING CHILDREN	NUMBER OF MISCARRIAGES
NUMBER OF FULL TERM PREGNANCIES	NUMBER OF CAESAREAN SECTIONS	NUMBER OF ABORTIONS
NUMBER OF PREMATURE DELIVERIES	NUMBER OF STILLBIRTHS	NUMBER OF ECTOPIC PREGNANCIES

DID YOU HAVE ANY PROBLEMS / COMPLICATIONS **DURING** PREGNANCY? (CHECK ALL THAT APPLY)

HIGH BLOOD PRESSURE ☐ DIABETES ☐ PRETERM LABOR ☐ OTHER ☐

DID YOU HAVE ANY PROBLEMS / COMPLICATIONS **AFTER** PREGNANCY? (CHECK ALL THAT APPLY)

INFECTION ☐ EXCESSIVE BLEEDING ☐ OTHER ☐

DID ANY OF YOUR CHILDREN HAVE ANY BIRTH DEFECTS OR GENETIC PROBLEMS? Y N IF YES, PLEASE DESCRIBE:

BIRTH CONTROL PLEASE CHECK ALL THAT APPLY

CURR	PAST		CURR	PAST		CURR	PAST	
☐	☐	PILLS	☐	☐	DEPO-PROVERA	☐	☐	WITHDRAWAL
☐	☐	CONDOM	☐	☐	NEXPLANON	☐		SELF STERILE
☐	☐	IUD	☐	☐	NUVARING	☐		PARTNER STERILE

HOW LONG HAVE YOU USE CURRENT METHOD?

IF YOU HAVE HAD ANY PROBLEMS WITH THESE METHODS, DESCRIBE:

IF YOU WANT A BIRTH CONTROL METHOD NOW, INDICATE WHICH METHOD:

DO YOU WANT TO HAVE CHILDREN IN THE FUTURE? Y N

PAP TEST DATE OF LAST EXAM ____/____/____ ☐ NORMAL ☐ ABNORMAL

HAVE YOU EVER HAD AND ABNORMAL PAP SMEAR? Y N SPECIFY:

INFECTIONS AT PRESENT ANY ABNORMAL VAGINAL DISCHARGE? Y N

HISTORY OF:

☐ YEAST INFECTIONS	☐ CHLAMYDIA	☐ GONORRHEA	☐ BACTERIAL INFECTION
☐ URINARY INFECTIONS	☐ HERPES	☐ HPV	☐ TRICHOMONAS

YEAR OF LAST: MAMMOGRAM /_____ COLONOSCOPY /_____ BONE DENSITY TEST /_____

PLEASE READ AND SIGN: "I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT AND COMPLETE"

X _____ DATE ____/____/____