Personal Past Medical History

	Date
Abnormal PAP Smear	
Abnormal Uterine Bleeding	
Anemia	
Anxiety	
Asthma	
Bleeding Disorder	
Cancer:	
Chlamydia	
Deep Vein Thrombosis (DVT)	
Depression	
DES Exposure	
Diabetes	
Eating Disorder:	
Endometriosis	
Epilepsy	
Esophageal Reflux (GERD)	
Fibrocystic Changes of the Breast	
Fibroids, Uterine	
Gastrointestinal Disorder:	
Genital Warts	
Gestational Diabetes	
Heart Attack / Disease	
Hematuria (Blood in urine)	
Hepatitis	
Herpes Simplex, Genital	
High Blood Pressure	
High Cholesterol	
Human Immunodeficiency Virus (HIV)	
Human Papilloma Virus (HPV)	
Infertility, Female	
Irritable Bowel Syndrome	
Kidney Disease:	
Liver Disease	
NONE	
Osteoporosis	
Other STDs:	
Ovarian Cyst	
Pelvic Inflammatory Disease	
Pelvic Pain	
Polycystic Ovaries	
Postmenopausal Bleeding	
Premenstrual Tension Syndrome (PMS)	
Previous Blood Transfusion	
Psychiatric Problems	
Respiratory Disorder	
Sexual Dysfunction	
Sickle Cell Anemia	
Stroke	
Thyroid Disorder	
Urinary Incontinence	
Urinary Tract Infection	
Uterine Prolapse	
Other:	
Other:	

Health Maintenance

Name of Primary Physician	Date
Last Mammogram	
Last Exam and/or pap	
Last Cholesterol Check	
Last Bone Density	
Last Colonoscopy	

Past Surgical History

	Date
Ablation	
Appendectomy (Appendix)	
Back Surgery	
Bladder Surgery	
Breast Surgery	
Cervical Procedure	
Cesarean Section	
Cholecystectomy (Gall Bladder)	
Dilation and Curettage (D & C)	
Ectopic Pregnancy	
Hysterectomy	
Hysteroscopy (Exploration of the Uterus)	
Knee Surgery	
Laparoscopy (Exploration of the Abdomen)	
NONE	
Other	
Ovarian Surgery	
Thyroidectomy	
Tubal Ligation / Essure	

Allergy List

NO KNOWN ALLERGIES

Allergic to:	Reaction:

Family Medical History

M=Maternal
P=Paternal

Disease Name	Relative	Age onset	
Blood Disorder			M P
Breast Cancer			M P
Cervical Cancer			M P
Colon Cancer			M P
Diabetes			M P
Heart Disease			M P
High Blood Pressure			M P
High Cholesterol			M P
Mental Illness / Depression			M P
			M P
NONE			
Osteoporosis			M P
Other			M P
Ovarian Cancer			M P
Stroke			M P
Thyroid Disorder			M P
Uterine Cancer			M P
			M P

Date Completed:

Patient Name:

DOB:

Medication List

Current Medication	Indication	Dosage	Prescribing Doctor

Date Completed:

Genetic History

	Disease Name	Relation
	Congenital Heart Defect	
	Cystic Fibrosis	
	Down Syndrome	
	Hemophilia	
	Mental Retardation/Autism	
	Metabolic Disorder (PKU, Diabetes)	
	Muscular Dystrophy	
	Neural Tube Defect/Spina Bifida	
	NONE	
	Other Inherited Genetic or Chromosomal D/O	
	Other:	
	Sickle Cell Anemia	
	Tay-Sachs Disease	
	Thalassemia	

Reproductive History (Menstrual)

Age at 1st Period			
# Of Days From Start Of Period To Next One			
Menses # of Days of Flow			
Amount Of Flow	Light	Medium	Heavy
Last Menstrual Period			
Age Menopause (If Applicable)			
Method of Birth Control:			
Clots		No	Yes
Breakthrough Bleeding		No	Yes
On Hormone Replacement Therapy (HRT)		No	Yes

Reproductive History (Pregnancy)

Pregnancy Summary (including miscarriages, ectopic, abortion)

Total Pregnancy	Full Term	Premature	Abortion Induced	Miscarriage	Ectopics	Multiple	Living

Pregnancy Details (Anesthesia types: Epidural, General, IV Meds, Local, None Spinal)

Date	GA (weeks)	Hrs Labor	Birth WT	Sex	Delivery Type	Anesthesia	Early Labor	Complications

Social History

Have you ever been sexually active? No Yes Are you currently sexually active? No Yes

Marital Status: Bisexual Dating Divorced Engaged Lesbian Married Not-dating Single Widowed

Education Level: High School Some College/AA Degree College Graduate Degree Post Other:

Occupation:

Exercise: Sedentary Active but no formal Minimal (1 per week) Moderate (1-3 per week) Heavy (4 or more per week)

Substance Use:				Name/type	amount	age started	age stop	other information
Alcohol	*Never*	*Current*	*Former*					
Illegal Drugs	*Never*	*Current*	*Former*					
Tobacco	*Never*	*Current*	*Former*					

Have you engaged in abusive behavior towards others? No Yes

Have you been emotional / physically / sexually abused or threatened by anyone? No Yes

Do you wear your seat belt? No Yes

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