

Personal Past Medical History		Health Maintenance	
	Date		Date
Abnormal PAP Smear		Last Mammogram	
Abnormal Uterine Bleeding		Last Exam and/or pap	
Anemia		Last Cholesterol Check	
Anxiety		Last Bone Density	
Arthritis		Last Colonoscopy	
Asthma			
Bleeding Disorder			
Cancer:			
Chickenpox			
Chlamydia			
Deep Vein Thrombosis (DVT)			
Depression			
DES Exposure			
Diabetes			
Eating Disorder:			
Endometriosis			
Epilepsy			
Esophageal Reflux (GERD)			
Fatigue			
Fibrocystic Changes of the Breast			
Fibroids, Uterine			
Gastrointestinal Disorder:			
Genital Warts			
Headache			
Heart Attack / Disease			
Hematuria (Blood in urine)			
Hepatitis			
Herpes Simplex, Genital			
High Blood Pressure			
High Cholesterol			
Human Immunodeficiency Virus (HIV)			
Human Papilloma Virus (HPV)			
Incontinence of Urine			
Infertility, Female			
Irregular Periods			
Irritable Bowel Syndrome			
Kidney Disease:			
Liver Disease			
NONE			
Osteoporosis			
Other STDs:			
Ovarian Cyst			
Pelvic Inflammatory Disease			
Pelvic Mass			
Pelvic Pain			
Polycystic Ovaries			
Postmenopausal Bleeding			
Premenstrual Tension Syndrome (PMS)			
Previous Blood Transfusion			
Psychiatric Problems			
Recent Rash or viral illness			
Respiratory Disorder			
Sexual Dysfunction			
Sickle Cell Anemia			
Stroke			
Thyroid Disorder			
Tuberculosis (TB)			
Urinary Tract Infection			
Uterine Prolapse			
Other:			
Other:			

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

Allergy List	
NO KNOWN ALLERGIES	
Allergic to: _____ Reaction: _____	

Family Medical History			M=Maternal	P=Paternal
Disease Name	Relative	Age onset		
Alzheimer's			M	P
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
NONE				
Osteoporosis			M	P
Other			M	P
Ovarian Cancer			M	P
Stroke			M	P
Thyroid Disorder			M	P
Tuberculosis			M	P
Uterine Cancer			M	P

Date Completed:

Patient Name:

DOB:

Medication List

Current Medication	Indication	Dosage	Prescribing Doctor

Genetic History		Reproductive History (Menstrual)			
Disease Name	Relation				
<input type="checkbox"/> Canavan Disease	_____	Age at 1st Period _____			
<input type="checkbox"/> Congenital Heart Defect	_____	Cycle Interval Days _____			
<input type="checkbox"/> Cystic Fibrosis	_____	Menses Duration Days _____			
<input type="checkbox"/> Down Syndrome	_____	Flow _____		Light	Medium Heavy
<input type="checkbox"/> Hemophilia	_____	Last Menstrual Period _____			
<input type="checkbox"/> Huntington Chorea	_____	Menopause Status _____		Pre	Peri Post
<input type="checkbox"/> Mental Retardation/Autism	_____	Age Menopause _____			
<input type="checkbox"/> Metabolic Disorder (PKU, Diabetes)	_____	Method of Birth Control:			
<input type="checkbox"/> Muscular Dystrophy	_____	Cervical Cap	Condoms	Depo Provera	
<input type="checkbox"/> Neural Tube Defect/Spina Bifida	_____	Diaphragm	IUD	OCPs (BC pills)	
<input type="checkbox"/> NONE	_____	OTC (foam, jelly, etc)	Other	NONE	
<input type="checkbox"/> Other Inherited Genetic or Chromosomal D/O	_____	Rhythm Method	Sterilization	Tubal Ligation	
<input type="checkbox"/> Other: _____	_____	Vasectomy	Withdrawal		
<input type="checkbox"/> Sickle Cell Anemia	_____	Clots		No	Yes
<input type="checkbox"/> Tay-Sachs Disease	_____	Breakthrough Bleeding		No	Yes
<input type="checkbox"/> Thalassemia	_____	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
Tobacco	Never Current Former				
Alcohol	Never Current Former				
Caffeine	Never Current Former				
Prescription ABUSE	Never Current Former				
Other	Never Current Former				
Illegal Drugs	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