

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	
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	Reproductive History (Menstrual)			
Canavan Disease		Age at 1st Period			
Congenital Heart Defect		Cycle Interval Days			
Cystic Fibrosis		Menses Duration Days			
Down Syndrome		Flow	Light	Medium	Heavy
Hemophilia		Last Menstrual Period			
Huntington Chorea		Menopause Status			
Mental Retardation/Autism		Age Menopause			
Metabolic Disorder (PKU, Diabetes)		Method of Birth Control:			
Muscular Dystrophy		Cervical Cap	Condoms	Depo Provera	
Neural Tube Defect/Spina Bifida		Diaphragm	IUD	OCPs (BC pills)	
NONE		OTC (foam, jelly, etc)	Other	NONE	
Other Inherited Genetic or Chromosomal D/O		Rhythm Method	Sterilization	Tubal Ligation	
Other:		Vasectomy	Withdrawal		
Sickle Cell Anemia		Clots		No	Yes
Tay-Sachs Disease		Breakthrough Bleeding		No	Yes
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

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