

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

  

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

  

Allergy List	
<input type="checkbox"/> <b>NO KNOWN ALLERGIES</b>	
Allergic to:	Reaction:

  

Family Medical History			M=Maternal P=Paternal
Disease Name	Relative	Age onset	
<input type="checkbox"/> Alzheimer's			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> Blood Disorder			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> Breast Cancer			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> Cervical Cancer			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> Colon Cancer			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> Diabetes			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> Heart Disease			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> High Blood Pressure			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> High Cholesterol			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> Mental Illness / Depression			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> <b>NONE</b>			
<input type="checkbox"/> Osteoporosis			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> Other			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> Ovarian Cancer			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> Stroke			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> Thyroid Disorder			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> Tuberculosis			M <input type="checkbox"/> P <input type="checkbox"/>
<input type="checkbox"/> Uterine Cancer			M <input type="checkbox"/> P <input type="checkbox"/>

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"/> <b>NONE</b>	_____	OTC (foam, jelly, etc)	Other	<b>NONE</b>	
<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