Patient Name:

DOB:

Date Completed:

Personal Past Medical History

	Condition	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	
☐	MRSA (Methicillin-Resistant Staphylococcus Aureus)	
☐		
☐	***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

	Item		Date
☐	Name of Primary Physician		
☐	Preferred Pharmacy		
☐	Gardasil Vaccination Completed	YES / NO	
☐	Last Mammogram		
☐	Last Exam and/or pap		
☐	Last Cholesterol Check		
☐	Last Bone Density		
☐	Last Colonoscopy		

Past Surgical History

	Procedure	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 ☐

Please Complete Side 2 ⇒

Medication List

Current Medication	Indication	Dosage	Prescribing Doctor

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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