NAME _____ **AGE** _____ **DOB** _____
DATE OF VISIT _____ **REASON FOR VISIT** _____
APPT. WITH _____

MEDICAL HISTORY	Y	N	EXPLAIN	PROVIDER NOTES
1. Eye, ear, nose, throat problems				
2. Respiratory: asthma tuberculosis other				
3. Cardiac: heart disease Murmur, high cholesterol high blood pressure other				
4. Breasts: prior surgery or biopsy Breast pain Breast lump Mammography			when _____	
5. GI: ulcers, IBS, constipation Colitis, hemorrhoids other				
6. Neurologic: seizures migraines other				
7. Urinary: bladder infection kidney problems urine leakage other				
8. Musculoskeletal: arthritis other				
9. Endocrine: diabetes, osteoporosis thyroid disease other				
10. Bleeding disorder anemia varicose veins sickle cell blood clots other Have you ever had a transfusion? Y N				
11. Skin disease				
12. Psychiatric disorders: depression, counseling hospitalization medications			when _____	

13. Surgical procedures: Date

_____

_____

14. Medications (include dose and vitamins):

_____

Patient Name: _____ **DOB:** _____

15. Drug allergies: _____

16. Social History: Alcohol_____drinks/week Caffeine _____cups/day
Cigarettes _____/day Street drugs Yes No Past use
Have you been involved in violence? Yes No Sexual abuse: Yes No
Do you feel safe at home? Yes No Do you Exercise? Yes No

17. Obstetric History: Total pregnancies ____ Term ____ Premature ____ Miscarriage ____
Abortion ____

PAST PREGNANCIES (LAST SIX)

DATE MO/YR	WEEKS @ birth	LENGTH OF LABOR	BIRTH WT.	SEX M/F	TYPE DEL.	ANES.	PLACE OF DELIVERY	COMMENTS/ COMPLICATIONS

18. Gynecology History
Do you desire future pregnancies? Yes No Unsure When:_____
Have you had Rubella? Yes No DES exposure: □ Yes No
Current birth control : _____

Menstrual History
Last period _____ # days bleeding _____
Are your periods regular? Yes No
every _____ days
Bleeding between periods □ Yes No
Bleeding after sex Yes No
Pain with periods Yes No

PAP History
Last PAP _____ Normal □ Abnormal □
Have you had an abnormal PAP: Yes No
Results _____
Treatment _____

Sexual History
Are you currently sexually active? Yes No
Have you ever had:
Herpes: Yes No Gonorrhea: Yes No
Chlamydia: Yes No PID: □ Yes No
Genital Warts/HPV: Yes No Syphilis: Yes No
Are you having sexual problems? Yes No Describe: _____

General History
Do you have bothersome vaginal discharge? Yes No Describe _____
Have you ever had:
Fibroids □ Yes No Ovarian cysts Yes No
Endometriosis □ Yes No Other _____

Menopause History
Are you post-menopausal? □ Yes No Age last period _____
Symptoms _____
Are you on hormones? □ Yes No Have you ever taken hormones? Yes No□

19. Family History:

	LIVING Age	LIVING Health	DECEASED Age	DECEASED Cause
Mother				
Father				
#1 Bro/Sis				
#2				
#3				
#4				

Any Family History: Breast cancer _____Ovarian Cancer _____Colon Cancer_____
Heart disease _____ Diabetes _____