

MEDICAL HISTORY

Name: _____

Date of Birth: _____

Past Medical History:

Last Pap Smear Date: _____ Normal? No Yes Ever had an abnormal Pap Test? No Yes

Last Mammogram Date: _____ Normal? No Yes Ever had an abnormal Mammo Test? No Yes

Have you had a Bone Density Scan? No Yes- date & result _____

Have you had a Colonoscopy? No Yes- date & result _____

Specify/Check Any Problems you have had and the Date of Diagnosis:

Pregnancy: _____

Gynecology: (Uterus, Cervix, Ovaries) _____

STD: HPV Trich Chlamydia Gonorrhea Herpes Hepatitis B or C HIV Syphilis

Breasts: Cancer Mass Biopsy _____

Heart: High Blood Pressure Heart Disease _____

Digestive Disorders: Reflux IBS Cancer _____

Endocrine: Diabetes Thyroid Disease _____

Blood: Anemia Blood Transfusion Sickle Cell Trait or Disease Clotting Disorders _____

Musculoskeletal: Arthritis Scoliosis Osteopenia or Osteoporosis _____

Neurological: Migraines Seizures _____

Psychiatric: Anxiety Depression Suicide Attempt Eating Disorder _____

Respiratory: Asthma Tuberculosis test positive _____

Skin Disorders: Skin Cancer Psoriasis _____

Urology: Frequent Bladder Infections Kidney Stone _____

Seasonal Allergies: _____

Surgical History: Tonsillectomy Appendectomy Gallbladder Removal Bladder Surgery
 Kidney Stones Removed Hernia Repair Thyroid Surgery C-Section Sterilization/Tubal Ligation
 Hysterectomy with Removing Ovaries Ovary Cyst Aspirated or Removed Cervix Surgery Colposcopy
 CRYO Freezing Laser or LEEP or Cone of Cervix Breast Reduction Breast Augmentation
 Any Cancer Surgery Other: _____

****Please Include Approximate Dates for Surgeries- if you've had any type of hysterectomy state type AND reason****

Social History:

Alcohol: None Occasional 1-4 Drinks per week 5 or more per week

Tobacco Use: No Yes How many a day: _____

Education Level: High School GED Diploma College Graduate Studies Post-Graduate
 I am a Student now

Exercise: None 1-3 x week 4 or more x week

PLEASE TURN PAGE OVER AND FILL OUT BACK SIDE

Relationship History

- Single Dating Not Dating Long-term partner Engaged Married Separated
- Divorced Widowed Same Sex Relationship

Would you like to discuss Abuse (Emotional, Physical, or Sexual)? Yes No No Abuse

Birth Control Methods: Condoms Birth Control Pills Nuva Ring Patch Depo Shot Diaphragm
 Abstinence Rhythm / NFP Withdrawal IUD Tubes Tied Partner with Vasectomy Desire Pregnancy

Reproductive History:

Menstrual History: Age Menses First Started _____

First Day of Last Menstrual Period: _____ or **Year of Last Period** _____ (Menopause)

Duration of Menses: _____ Interval = every _____ Days

Flow: Light Medium Heavy Days Cycle Clots

Pregnancy History: Total Number Pregnancies: _____ Currently Pregnant: No Yes Live Births: _____
Full Term (37 weeks or more): _____ Premature (less than 37 weeks): _____ Miscarriages: _____
Ectopic Pregnancies: _____ Voluntary Abortions: _____ Living Children: _____

Birth History: Please fill this in for each of your children if you are pre-menopausal from first birth to current

Birth Date	Full Term?	Hrs of Labor	Birth Wt.	Sex	Vaginal, Vacuum, Cesarean?	Epidural?	Location

Family Medical History: Family History Unknown Adopted

****Include approximate age at which family member was diagnosed**

Heart Disease (Cardiac)

High Blood Pressure: _____

Heart Attack: _____

Stroke: _____

Blood Clots in a Leg or Lung: _____

Endocrine Problems: Diabetes _____

Thyroid Disease _____

Cancer (Neoplasms) Which kind? (Breast, Uterus, Ovary, Colon, Lung)

Use Abbreviations

M (Mother)

F (Father)

B (Brother)

S (Sister)

MGM (Maternal Grandmother)

PGM (Paternal Grandmother)

MGF (Maternal Grandfather)

PGF (Paternal Grandfather)

A (Aunt) **U** (Uncle)

Genetic problems like, Sickle Cell Trait, Cystic Fibrosis, Other: _____

Medications: List ALL medications, doses, & reason for taking (include over the counter meds, supplements)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medication Allergies: None List ALL medications that you are allergic to AND reaction you have:

Allergy to Penicillin Latex Iodine Other: _____

Immunizations:

Have you gotten the Gardasil® vaccine to prevent Human Papilloma Virus?

- Yes No No, I am over 26 years old, No, but I am interested in more information