MEDICAL HISTORY

Name: _____ **Date of Birth:** _____

Chief Complaint:_____

Medication Allergies:
□ No Known Drug Allergies □ Allergy to Penicillin □ Latex □ Iodine
□ Other:_____
List ALL medications that you are allergic to AND reaction you have:
_____

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

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

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
If yes, how many injections? _____

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

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

Are you currently breastfeeding? _____

Possible Zika Exposure: Have you recently traveled overseas? _____ If yes, please list date: _____

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

Please select and list date, if you've had a history of the following:

- **Gestational Diabetes Mellitus:** _____
- **Preeclampsia:** _____

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 _____

History of PCOS _____

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

_____

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

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)

Social History:

Tobacco Use: □ No □ Yes How many a day: _____

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

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

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

Relationship History:

□ Married □ Single □ Dating □ Not Dating □ Long-term partner □ Engaged
□ Separated □ Divorced □ Widowed □ Same Sex Relationship
Is there any history of abuse? _____ Would you like to discuss? _____

Surgical History:

□ No history of surgeries
□ 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****

Past Medical History:

Last Pap Smear Date: _____ Normal? □ No □ **Yes** **Ever had an abnormal Pap Test**? □ No □ Yes
Date of abnormal pap smears:_____
Last Mammogram Date: _____ Normal? □ No □ **Yes Ever had an abnormal Mammo Test?** □ No □ Yes
Have you had a Colonoscopy? □ No □ Yes- date & result: _____
Have you had a Bone Density Scan? □ 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 □Postpartum Depression _____
- **Respiratory:** □ Asthma □ Tuberculosis test positive _____
- **Skin Disorders:** □ Skin Cancer □ Psoriasis _____
- **Urology:** □ Frequent Bladder Infections □ Kidney Stone _____
- **Seasonal Allergies**: □ _____