PATIENT HISTORY

Name _____ Age _____ Last Menstrual Period _____ Today's Date _____

Who is your Primary Care (medical) Doctor? _____ Height _____

CHIEF COMPLAINT: Why are you here today?

PAST MEDICAL HISTORY
List all SURGERIES or OPERATIONS you have had—include tonsils, appendix, wisdom teeth, laparoscopies, etc.

Operation	Date	Doctor/Hospital

Have you ever had general anesthesia (put to sleep)? NO YES Complications? NO YES Type:

List other (nonsurgical) hospital admissions—include those for kidney stones, pneumonia, etc.

Have you (**You**) or any family member (**Fam**) suffered from the following? Please mark an "X" if yes.

You	Fam		You	Fam	
☐	☐	convulsions/seizures	☐	☐	bleeding disorders/hemophilia
☐	☐	thyroid disease	☐		mitral valve prolapse
☐	☐	breast cancer	☐		blood clots in legs or lungs
☐	☐	heart murmur/heart disease	☐		frequent bladder infections
☐	☐	birth defects/malformations	☐		hepatitis/jaundice
☐	☐	tuberculosis	☐		anemia
☐	☐	asthma	☐		blood transfusion
☐	☐	high blood pressure	☐		drug or alcohol abuse
☐	☐	kidney disease/kidney stones	☐		DES exposure in utero
☐	☐	sickle cell anemia/thalassemia	☐		endometriosis
☐	☐	diabetes	☐		infertility
☐	☐	cancer type:	☐		depression
☐	☐	rectal/colon problems			

MEDICATIONS: List the name and dose of any drugs you take regularly (include birth control pills, vitamins, and herbs)

List DRUG ALLERGIES/sensitivities and reaction type—rash, hives, shortness of breath, nausea, etc.

How many cigarettes do you smoke a day? How much alcohol do you drink each day?

What recreational drugs do you use?

MENSTRUAL HISTORY
Age of first bleed _____ Do you cycle about every 28 days? YES If NO, how often? _____ Days of flow _____

Are your periods regular NO YES Do you have pain or cramps with your period? NO YES
If yes, what medications help?

When was your last pap smear? _____
Have you ever had an ABNORMAL PAP SMEAR? NO YES If yes, when and how was it treated?

Check any of the infections you have had: What YEAR?

- ☐ gonorrhea
- ☐ genital herpes
- ☐ genital warts (condyloma)
- ☐ chlamydia
- ☐ syphilis
- ☐ HIV/AIDS
- ☐ PID (pelvic inflammatory disease)/tubal infection

Have you been tested for the HIV (AIDS) virus? NO YES When? _____ What was the result? _____

Do you know how to examine your breasts? NO YES Do you examine your breasts each month? NO YES

When was your last MAMMOGRAM? _____ What was the result? _____

With whom do you have sex? women men both neither

Check any of the following methods of BIRTH CONTROL you have used:

Method	Dates of usage	Problems
☐ condom		
☐ foam		
☐ diaphragm		
☐ Norplant		
☐ Depo-Provera		
☐ oral contraceptives or “the pill”		
☐ intrauterine device (IUD)		
☐ rhythm		

OBSTETRICAL HISTORY

How many times have you been pregnant? _____

Check if you have had any of the following? How MANY and what YEAR?

- ☐ vaginal deliveries
- ☐ cesarean sections
- ☐ ectopic or tubal pregnancies
- ☐ premature labor/deliveries
- ☐ miscarriages
- ☐ abortions
- ☐ babies with birth defects

DELIVERIES

	Date	#weeks	Weight	Sex	Hours in labor	Vaginal/cesarean	Complications—mom/child	Doctor
①								
②								
③								
④								

FAMILY HISTORY

	Age	Health problems	If deceased, age and cause
Mother			
Father			
Sister(s)			
Brother(s)			

_____
YOUR SIGNATURE, PLEASE