

Medical History

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except with your prior authorization.

Name: _____ Age: _____ Date: _____

Date of Last Physical Examination: _____ Date of Last PAP Smear: _____

Reason for Today's Visit: Routine / Annual Examination
 Present Symptoms / Complaints: _____

GYN HISTORY:

Date of Last Menstrual Period: _____ Age of First Period: _____

How many days apart are your periods (1st day to 1st day): 25 – 26 – 27 – 28 – 29 – 30 Other: _____

How many days do you bleed: 3 – 4 – 5 – 6 – 7 Other: _____ Cramps: Mild Moderate Severe

How many total pads do you use: _____ How many total tampons do you use: _____

Current Contraception: Pill Name of Pill: _____
 Condoms Tubal Ligation Diaphragm
 Vasectomy Foam I. U. D.
 Norplant Other: _____

Have you ever had an abnormal pap smear: Yes No

Have you ever had any of the following: Herpes Gonorrhea HIV Positive
 Syphilis Chlamydia Condyloma (Genital Warts)

OB HISTORY:

How many times have you been pregnant: _____

How many babies have you delivered: (Vaginal) _____ (Cesarean) _____

How many miscarriages have you had: _____ How many abortions have you had: _____

Deliveries:

<u>Year</u>	<u>Weight</u>	<u>Sex</u>	<u>Hours of Labor</u>	<u>Full Term</u>	<u>Location</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

PAST MEDICAL HISTORY

Have you ever had: Diabetes High Blood Pressure Heart Disease

Please list all surgeries that you have had including the year it was performed.

Have you ever been hospitalized for reasons other than surgery? If yes, please list when and why:

ALLERGIES: Please list all allergies to medications:

HABITS:

Tobacco: # of cigarettes per day: _____ Alcohol: # of drinks per day / week / month: _____

If you drink, what type of alcohol do you use: _____

Do you or have you ever used any of the following for recreation:

Crack / Cocaine Marijuana Heroin Other: _____

MEDICATION: Please list all medications you are currently taking:

FAMILY HISTORY: Please list all blood relatives with the following diseases:

Diabetes: _____ Heart Disease: _____

High Blood Pressure: _____ Cancer: _____

REVIEW

Do you suffer from:	Yes	No
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Psychological or Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>

OTHER COMMENTS
