

PATIENT HISTORY

Name _____ Date _____ Primary care M.D. _____
 Address _____ City _____ Zip _____
 Phone _____ Age _____ Birth date _____
 Marital status M D S W Occupation _____

PERSONAL HISTORY

Drug allergies: _____

Any surgeries: _____

Type of surgery(include cervix surgery) year done:

Medications:	Type	Dosage
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List any current medical problems you have:

Tobacco: No Yes _____Packs/Day

Alcohol: None Occasionally Daily

MEDICAL HISTORY

Do you have or have you ever had (please check all that apply)

	Yes	No	When
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibroids	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ovarian cysts/tumors	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

FAMILY HISTORY

Does any blood relative have or ever had:

	Yes	No	Who
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cervical cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (please list other)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clots in veins	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endometriosis cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____

MENSTRUAL HISTORY

Age at start: _____ Regular? Yes No

Cycle length: _____

(every how many days): _____

Usual duration: _____ days

Flow: Light Medium Heavy

Pain or Cramps? Yes No

Ever missed a period? Yes No

First day of last menstrual period: _____

GYNECOLOGICAL HISTORY

Is this your first pelvic exam? Yes No

Date of your last pelvic exam: _____

Any history of abnormal pap smears? Yes No

Dates? _____

What was the problem? _____

CHECK IF YOU HAVE EVER HAD:

Venereal warts Gonorrhea Herpes PID

Other Syphilis Trichomonas Chlamydia

Did your mother take the drug DES when she was pregnant with you? Yes No

Do you do breast self examinations? Yes No

How often? _____

When was your last mammogram? _____

PATIENT HISTORY

CONTRACEPTIVE HISTORY

Present method of birth control. _____
Any problems with this method? _____
How long have you used this method? _____

Have you ever used birth control pills Yes No
Circle other method you have used: Pills Suppositories Condom Diaphragm Rhythm Withdrawal
Vasectomy IUD Foam Patch Tubal Lig. Other _____

Have you ever been pregnant? Yes No
Number of pregnancies _____ Number of children _____
Number of: Full term _____ Premature _____ Miscarriages _____ Stillbirths _____
Ectopic Preg _____ Abortions _____
Delivery Type: Vaginal _____ C-section _____ Why? _____
Are you presently sexually active? Yes No

Dates of pregnancies: _____

Any complications/problems with pregnancy (circle)
Diabetes High blood pressure Bleeding Preterm labor DES problems Other

Any complications after deliver? (circle) Infection Excessive bleeding Other

Please sign: _____
Signature Date
