NAME ________________________ **AGE** _____________ **DOB** ____________________
DATE OF VISIT ________________________ **REASON FOR VISIT** ______________________
APPT. WITH _____________________________

MEDICAL HISTORY	Y	N	EXPLAIN	PROVIDER NOTES
1. Eye, ear, nose, throat problems				
2. Respiratory: asthma tuberculosis other				
3. Cardiac: heart disease Murmur, high cholesterol high blood pressure other				
4. Breasts: prior surgery or biopsy Breast pain Breast lump Mammography			when _______	
5. GI: ulcers, IBS, constipation Colitis, hemorrhoids other				
6. Neurologic: seizures migraines other				
7. Urinary: bladder infection kidney problems urine leakage other				
8. Musculoskeletal: arthritis other				
9. Endocrine: diabetes, osteoporosis thyroid disease other				
10. Bleeding disorder anemia varicose veins sickle cell blood clots other Have you ever had a transfusion? Y N				
11. Skin disease				
12. Psychiatric disorders: depression, counseling hospitalization medications			when _______	

13. Surgical procedures: Date

____

____

14. Medications (include dose and vitamins):

____

Patient Name: ____ **DOB:** _____________

15. Drug allergies: ____

16. Social History: Alcohol_____drinks/week Caffeine _____cups/day
    Cigarettes _____/day Street drugs Yes No Past use
    Have you been involved in violence? Yes No Sexual abuse: Yes No
    Do you feel safe at home? Yes No Do you Exercise? Yes No

17. Obstetric History: Total pregnancies ____ Term ____ Premature ____ Miscarriage ____
    Abortion ____

PAST PREGNANCIES (LAST SIX)

DATE MO/YR	WEEKS @ birth	LENGTH OF LABOR	BIRTH WT.	SEX M/F	TYPE DEL.	ANES.	PLACE OF DELIVERY	COMMENTS/ COMPLICATIONS

18. Gynecology History
    Do you desire future pregnancies? Yes No Unsure When:______________________
    Have you had Rubella? Yes No DES exposure: Yes No
    Current birth control : ____

Menstrual History
Last period _______ # days bleeding _____
Are your periods regular? Yes No
every _______ days
Bleeding between periods Yes No
Bleeding after sex Yes No
Pain with periods Yes No

PAP History
Last PAP _______ Normal Abnormal
Have you had an abnormal PAP: Yes No
Results ______________________________
Treatment ____________________________

Sexual History
Are you currently sexually active? Yes No
Have you ever had:
Herpes: Yes No
Chlamydia: Yes No
Genital Warts/HPV: Yes No
Gonorrhea: Yes No
PID: Yes No
Syphilis: Yes No
Are you having sexual problems? Yes No
Describe: ______________________________

General History
Do you have bothersome vaginal discharge? Yes No Describe ______________________________
Have you ever had:
Fibroids Yes No
Endometriosis Yes No
Ovarian cysts Yes No
Other ______________________________

Menopause History
Are you post-menopausal? Yes No Age last period ______________________________
Symptoms ____
Are you on hormones? Yes No Have you ever taken hormones? Yes No

19. Family History:

	LIVING Age	LIVING Health	DECEASED Age	DECEASED Cause
Mother				
Father				
#1 Bro/Sis				
#2				
#3				
#4				

Any Family History: Breast cancer _________Ovarian Cancer ________Colon Cancer___________
Heart disease _________________ Diabetes ______________________