Medical History

Name:___________________________________ Age______ DOB:___/___/____ Today's Date___/___/___
Current Occupation____

Gyn History

What was the date of your last pap smear_________
Have you been diagnosed with an abnormal pap smear? [ ] No [ ]Yes
If yes, when ____________________________________
Have you had or ever been advised you need a mammogram [ ] No [ ] Yes
Date of last mammogram___________
Are you currently sexually active? [ ] No [ ] Yes
What is your current method of contraception_________
Are your immunizations current? [ ] No [ ] Yes
Have you been diagnosed and/or treated for: [ ] Herpes [ ] Gonorrhea [ ] Chlamydia [ ] HIV [ ] Vaginal infections [ ] Pelvic inflammatory disease
Do you: Smoke [ ] No [ ] Yes [ ] Quit If yes, number of cigarettes a day______, how many years______
If you have quit, what year___________
Alcohol [ ] No [ ] Yes If yes, amount consumed weekly__________________________________
Illicit drug use; (i.e. marijuana, cocaine, etc.)____
Current Medications:____
Drug Allergies:____

Menstrual History

Menstrual History
Age at onset of periods
Regular Cycles [ ] No [ ] Yes
Cycle length days (start to start)
Duration of flow days
Pain or cramps [ ] No [ ] Yes
Flow [ ]Light [ ] Moderate [ ] Heavy
First day of last menstrual period

Review of Systems

Do you have or have you had any of the following:

[ ] Anemia
[ ] Asthma/lung disease
[ ] Autoimune disorder
[ ] Bleeding disorder
[ ] Blood clots in legs
[ ] Blood transfusion
[ ] Heart disease/Murmur
[ ] Hepatitis/liver disease
[ ] High blood pressure
[ ] High cholesterol
[ ] Incest/Rape
[ ] Jaundice
[ ] Migraine headaches
[ ] Painful intercourse
[ ] Sexual dysfunction
[ ] Thyroid disorder
[ ] Varicose veins

Pregnancy/Delivery History

Yr. Del	Sex	Weight	Hrs of Labor	Hospital	Complications

Surgical/Procedure History

Year	Procedure/Surgery Performed

Urological History

Have you had any history of bladder or kidney infection? [ ] No [ ] Yes
Do you lose urine with coughing, sneezing or exercise? [ ] No [ ] Yes
Have you had surgery for urinary difficulties? [ ] No [ ] Yes
Do you have a history of kidney stones or blood in the urine? [ ] No [ ] Yes

Family History

Family Member	Age	Living	If deceased, cause of death
Mother			
Father			
Brother(s)			
Sister(s)			

Has any of your family had: (list relative)
Diabetes
High Blood Pressure
Breast Cancer
Ovarian Cancer
Endometriosis
Other hereditary disease

Is there a history of bleeding or easy bruising in you or your family? [ ] No [ ] Yes