

Medical History

Name _____ Age _____ Today's Date: _____

Address _____ Apt. _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ ext. _____ Cell () _____

Please leave a phone # where we can leave personal messages () _____

Date of Birth ____/____/____ SSN _____ Referred by _____

Marital Status: M S D W Occupation _____ Email Address: _____

Please provide Pharmacy # _____

GYNOCOLOGIC HISTORY:

Last Menstrual Period ____/____/____

Previous Menstrual Period ____/____/____

Menstrual interval _____ days

Duration of flow _____ days

Age of first menstruation _____

Cramps with Period (Yes) (No)

Present Contraception _____

Past Contraception _____

Last Pap Smear _____

Past Abnormal Pap Smear? (Yes) (No)

Last Mammogram _____

Are you sexually active? _____

Sexual preference _____

Do you have sexual difficulties? _____

Have you ever been sexually abused? _____

PAST INFECTIONS:

(please check all which apply)

Herpes

Gonorrhea

Genital Warts/HPV

Trichomonas

Syphilis

Chlamydia

Other _____

PREGNANCY HISTORY:

Total pregnancies _____ Live term births _____ Abortions _____

Premature births _____ Miscarriages _____ Stillbirths _____

Ectopic pregnancies _____ Previous C- section _____

ALLERGIES:

MEDICATIONS/VITAMINS/HERBAL SUPPLEMENTS: _____

MEDICAL HISTORY:

Heart Disease

Diabetes

Kidney Disease

Anemia

Hypertension

Genetic Disease

Seizure Disorder

Lung Disease

Mental Illness

Smoking

Drug Use

Alcohol use () occasional () regular

No problems

FAMILY HISTORY:

Heart Disease

Diabetes

Kidney Disease

Anemia

High Blood Pressure

Genetic Disease

Seizure Disorder

Cancer

Mental Retardation

Mental Illness

Multiple Pregnancy

Infertility

Other

FAMILY HISTORY:

Blood Clots/Stroke

Please list all surgeries: _____