



Medical History Form

DATE _____ NAME _____ DATE OF BIRTH _____ PHONE NUMBER _____

OCCUPATION _____ Primary Care Physician (name & number) _____

How did you hear about us? _____ Email _____

The following information will assist us in providing you the most excellent care. This information is a confidential record. Please fill out both sides of this form completely.

Have you ever had the following (circle all that apply)

- | | | | |
|------------------------------|-----------------------------|----------------------------|-------------------------------|
| Abnormal MMG | DVT/PE | High Blood Pressure | Ovarian Cyst |
| Abnormal Pap | Endometriosis | HIV/AIDS | Painful Periods |
| Anemia | Epilepsy | Irregular Vaginal Bleeding | Problem with Anesthesia |
| Arthritis | Fibroids-Uterus | Irritable Bowel/Colon | STD – History of |
| Asthma/Emphysema | Frequent Bladder Infections | Kidney Disease | Stroke |
| Blood Transfusion | Genetic Disorder | Liver Disorder | Thyroid - Low (Hypothyroid) |
| Cancer | GERD | Lupus | Thyroid - High (Hyperthyroid) |
| Clotting Disorder | Headaches/Migraines | Mitral Valve Prolapse | Vaginal Infections |
| Depression | Heart Disease | Osteopenia | Other: |
| Diabetes (Type I or Type II) | High Cholesterol | Osteoporosis | |

Your most recent:	Date	Result	Your most recent:	Date	Result
Mammogram			Cholesterol Check		
PAPS Test			Bone Density Scan		
Colonoscopy					

List all Surgeries and Procedures

Surgery/Procedure	Year Performed	Surgery/Procedure	Year Performed

List all prescription and over-the-counter medications and supplements you take regularly

Medication	Dose	Frequency (how often)	Prescribing Physician (or over the counter)

List all medication allergies and the reaction you have if you take them

Allergic To:	Reaction	Allergic To:	Reaction

Family History *Are You Adopted?* NO YES—if blood relative history unknown, proceed to page 2

Has any blood relative had any of the following? Indicate "M" for maternal, "P" for paternal family member (i.e. if your Mother's mother, write MGM)

Problem	Family Member** Please List**	Age Onset	Problem	Family Member	Age Onset
Anemia			Epilepsy		
Asthma			Heart Disease		
Blood Disorder			High Cholesterol		
Cancer – Breast			Hypertension		
Cancer – Colon			Kidney Disease		
Cancer – Ovarian			Migraines		
Cancer – Uterine			Stroke		
Cancer – Other			Thyroid Disorder		
Depression					
Diabetes, Type 1			Other		
Diabetes, Type II					

Gynecologic History

Age of first menstruation: _____

Menopause NO YES, since age _____

First day of most recent menstrual period: _____

How many days do your periods last? _____

How often do you get your period? _____

Do you bleed or spot between periods? NO YES

Number of sexual partners: in the last year _____

Lifetime _____

Have you ever been pregnant? NO YES

How many children have you had? _____

Are they all living? NO YES

Have you ever had a miscarriage? NO YES, how many? _____

Have you ever had an abortion? NO YES, how many? _____

Have you ever had an ectopic pregnancy? NO YES, how many? _____

Do you have any adopted children? NO YES, how many? _____

Current Birth Control Method (circle all that apply)

- | | | | | |
|-----------|-------------------------|-----------|--------------|-----------------|
| Virgin | Natural Family Planning | Foam/Gel | Patch | Tubal Ligation |
| Abstinent | Withdrawal | Diaphragm | Nuvaring | Hysterectomy |
| None | Condoms | IUD | Depo-Provera | No Male Partner |
| | | Pill | Vasectomy | |

Obstetric History

Date of delivery, miscarriage, abortion	# weeks at delivery	Length of labor	Sex of Baby	Type of delivery? (vaginal or C-section)	Birth Weight	Complications	Location/Doctor

Social History:

Name of Primary Physician: _____

Marital status: Single Engaged Married Divorced Widowed

Do you smoke? Never Former—Quit when? Yes—how much per day?

Do you drink alcohol? Never Yes—how much and how often?

Do you use illegal drugs? Never Yes—what kind, how much and how often?

Do you drink caffeine? No Yes—what kind and how often?

How much exercise do you get? Sedentary 1-2 times/mo 1-2 times/wk 3-4 times/wk nearly every day daily

Do you use seatbelts? NO YES

Do you perform monthly breast self exams? NO Always Sometimes Never

Have you experienced sexual or physical abuse in the past or present? NO YES

Calcium Intake per day? # of Serving per day-_____ and/or supplements per day-_____mg

Please circle any symptoms you are currently having, or have had recently:

- | | | | | |
|---------------------|--------------------|---------------------|--------------------|---------------------|
| Weight gain | Breast Lumps | Blood in stools | Painful periods | Anxiety |
| Weight loss | Nipple discharge | Fecal incontinence | Irregular periods | Depression |
| Chronic fatigue | Lower leg swelling | Nighttime urination | Vaginal odor | Difficulty sleeping |
| Persistent Fever | Varicose veins | Blood in urine | New skin lesions | Swollen lymph nodes |
| Cough | Diarrhea | Frequent Urination | Changes in moles | Bleed easily |
| Shortness of Breath | Constipation | Bladder Discomfort | Hot flashes | Frequent illnesses |
| Changes in Vision | Nausea | Leaking urine | Night sweats | Seasonal allergies |
| Neck Stiffness | Vomiting | Genital sores | Hair loss | |
| Frequent Headaches | Abdominal Pain | Vaginal discharge | Facial hair growth | |