Medical History

Please complete form (print clearly)

and return to the office at the time of your appointment

Preferred Name: _____ **Date of Birth:** _____

Past Medical History

Last Pap Smear Date:_____ Normal? Yes ☐ No ☐ Ever had an Abnormal Pap Smear?: Yes ☐ No ☐

Last Mamogram Date:_____Normal?: Yes ☐ No ☐ Ever had an abnormal Mammogram? Yes ☐ No ☐

Have you had a Bone Density Scan?: No ☐ Yes ☐ Date & Results_____

Have you had a Colonoscopy?: No ☐ Yes ☐ Date & Results_____

Specify any Problems you have had with the following, including the date of diagnosis:

Gynecological: (Vagina, Uterus, Ttubes, Cervix,Ovaries) _____

STD: HPV ☐ Trich ☐ Chlamydia ☐ Gonorrhiea ☐ Herpes ☐ Hepatitis B or C ☐ HIV ☐ Syphillis ☐

Breasts: Cancer ☐ Mass ☐ Biopsy ☐ _____

Heart: High BP ☐ Heart Disease ☐ _____

Digestive Disorders: Reflux ☐ IBS ☐ Gluten Intolerance ☐ Lactose Intolerant ☐ Gall bladder ☐

Endocrine: Diabetes ☐ Thyroid Disease ☐ Other ☐ _____

Blood: Anemia ☐ Blood Transfusion ☐ Sickle Cell Trait or Disease ☐ Clotting Disorder ☐ _____

Musculoskeletal: Arthritis ☐ Scoliosis ☐ Osteopenia ☐ Osteoporosis ☐ Fractures ☐ _____

Neurological: Migraines ☐ Seizures ☐ _____

Psychiatric: Anxiety ☐ Depression ☐ Eating Disorder ☐ Suicide Attempt ☐ Other ☐ _____

Respiratory: Asthma ☐ Tuberculosis Test Positive ☐ _____

Skin Disorders: Eczema ☐ Psoriasis ☐ Skin Cancer ☐ _____

Urology: Frequent Bladder Infections ☐ Kidney Stones ☐ _____

Seasonal Allergies: ☐ _____

Surgical History Tonsillectomy ☐ Appendectomy ☐ Removal of Gallbladder ☐ Removal of Kidney Stones ☐

Bladder Surgery ☐ Hernia Repair ☐ Thyroid Surgery ☐ C- Section ☐ Tubal Ligation ☐ Hysterectomy ☐

Ovaries Removed ☐ Surgery to Cervix ☐ Colposcopy ☐ CRYO freezing ☐ Laser or LEEP ☐ Breast Surgery ☐

Any Cancer Surgery ☐ Other ☐ _____

Social History Alcohol**:** None ☐ Occasional ☐ 1-4 Drinks per Week ☐ 5 or more per week ☐

Tobacco Use: No ☐ Yes ☐ How many a day: _____ are you interested in stopping? No ☐ Yes ☐

Education Level: High School ☐ GED ☐ Diploma ☐ College ☐ Graduate Studies ☐ Post Graduate ☐
I am a student now: No ☐ Yes ☐ _____

Exercise Level: None ☐ 1-2 time per week ☐ 3 - 4 times a week ☐ Greater than 3-4 times per week ☐

Relationship History

☐ Single ☐ Dating ☐ Not Dating ☐ Long-Term Partner ☐ Engaged ☐ Married ☐ Separated

☐ Divorced ☐ Widowed ☐ Same Sex Relationship

Would you like to discuss Abuse – (Emotional, Physical or Sexual?) ☐ Yes ☐ No ☐ No Abuse

Birth Control Method: Desires pregnancy? ☐ Yes ☐ No

☐ Condoms ☐ Birth Control Pills ☐ Nuva Ring ☐ Patch ☐ Depo Shot ☐ Diaphragm

☐ IUD Type: MIRENA OR PARAGARD Year of IUD insertion: _____

☐ Tubes tied/partner with Vasectomy ☐ Natural/Rhythm ☐ Abstinenceal/Rhythm ☐ Withdrawal

Reproductive History:

Menstrual History: Age Periods started_____

First day of Last Menstrual Period:_____**or Year of Last Period**_____(Menopause)

Duration of Periods:_____Days **Interval between Periods**: Every _____Days

Flow: ☐ Light ☐ Medium ☐ Heavy - # of Days_____ Clots? ☐ Yes ☐ No

Pain: ☐ Light_____ ☐ Medium _____ ☐ Strong_____

Pregnancy History Total # of pregnancies:____Total # of Live Births:____Currently Pregnant: ☐ Yes ☐ No

Full Term (37 weeks or more): _____ Premature (less than 37 full weeks):_____Miscarriages:_____

Ectopic Pregnancies: _____Molar Pregnancy:_____Voluntary Abortions:_____Living Children:_____

Birth History Please fill this in for each of your children from the first birth.

Date of Birth	Full Term?	Hours of Labor ?	Birth Weight	Name	Delivery type	Epidural Yes/No	Episiotomy or laceration	Place of Delivery

Family History: ☐ History Unknown ☐ Adopted

Please Use Following Abbreviations: M (Mother) **F** (Father) **B** (Brother) **S** (Sister) **MGM** (Maternal Grandmother) **PGM** (Paternal Grandmother) **MGF** (Maternal Grandfather) **PGF** (Paternal Grandfather) **A** (Aunty) **U** (Uncle)

Include approximate age at which family member was diagnosed:

Heart Disease: High BP**:** _____
Blood Clots in leg or lungs: _____
Stroke: _____
Heart Attack**:** _____

Endocrine problems:
Diabetes_____
Thyroid Disease**:** _____

Cancers: Which Kind?

Deaths in Your Immediate Family? ☐ No ☐ Yes

Who, When and Cause and age of death?
_____
_____
_____

Genetic Problems - for example: Sickle Cell Trait, Cystic Fibrosis Other:_____
_____

Medications: List ALL medications, doses & reason for taking. Including supplements:
_____
_____
_____
_____

Medication Allergies: ☐ **None** **List all medication allergies and your reaction to them:**

☐ Penicillin _____
☐ Latex _____
☐ Other _____

Immunizations: Have you had Gardasil vaccine to prevent Human Papilloma Virus?

☐ Yes ☐ No – I am over 26 years of age ☐ No but I am interested in learning more about it.