Medical History Form

Name: _____
Date of Birth: ____/____/_____
Today's Date: ____/____/_____

Have you ever had any of the medical problems listed below? For any "yes" answers please circle and give details:

Diabetes
High Blood Pressure
Stroke
High Cholesterol
Heart Problems
Hepatitis (A, B, or C)
Gallstones
Kidney Stones
Kidney Infections
Seizures
Migraines
Thyroid Problems
Blood Clots in your legs or lungs
Asthma
Pneumonia
Tuberculosis
Depression
Anxiety
Eating Disorder
Bipolar Disorder
Alcoholism
Drug Use
Blood Transfusions
Anemia
Gastrointestinal Problems
Victim of Domestic Violence
Victim of Sexual Abuse

Please list any operations or hospitalizations you have had in your lifetime:

Year	Type of Operation or Reason for Hospitalization	Details/ Comments

What is the name of your family doctor, internist, or PCP? _____

List any medications or substances you are allergic to, and what reaction each one caused, (e.g. "rash"):
_____
_____

List any medications, (prescription or over-the-counter), including vitamins and supplements you are taking now:
_____
_____
_____
_____

Family History:

Please list any health problems in members of your immediate family:

Mother: _____
Father: _____
Sister(s): _____
Brother(s): _____
Children: _____

In your more extended family (aunts/uncles, grand-parents), has anyone had any of the following cancers? If so, how are they related to you (e.g. grandmother on my dad's side)?

Breast cancer? _____
Ovarian cancer? _____
Colon cancer? _____

Do either of your parents have osteoporosis? _____
Has either your mom or dad ever had a broken hip? _____

Gynecologic History:

Have you ever had any of these female problems? Please circle and give details for any "yes" answers:

Fibroids
Endometriosis
Ovarian cysts
Infertility
Polycystic Ovary Syndrome (PCOS)
Urinary incontinence
Heavy, prolonged, or irregular menstrual bleeding
Pelvic Pain
PMS
Breast problems or breast biopsies

Have you ever had an abnormal Pap? Yes/ No When? _____
Did you receive any treatment for this? Yes/ No
If "Yes," what treatment was done? (Freezing, laser, LEEP, cone biopsy.)
Did your Paps go back to normal after the treatment? Yes/No

Have you received the vaccine for HPV (Gardasil or Cervarix)? Yes/ No

Are you currently sexually active? Yes/ No
Have you had more than one sex partner in the past year? Yes/ No

Are you using contraception? Yes/ No
If "yes," which method? (Circle on list below.)

Birth control pills→ Which brand? _____
Birth control patch (Ortho Evra)
Birth control ring (NuvaRing)
Birth control shot (Depo-Provera)
Mirena IUD→ When was it inserted? _____
Paragard (copper) IUD→ When was it inserted? _____
Condoms
Diaphragm
Tubal ligation
Essure
Partner has Vasectomy
Natural Family Planning
Implanon→ When was it inserted? _____

Have you ever had any of these infections? Yes/ No (Circle any that apply and indicate when):

Chlamydia
Gonorrhea
Syphilis
HIV
HPV (Human Papilloma Virus)
Genital Herpes
Genital Warts
PID (Pelvic Inflammatory Disease or "tubal infection")

Menstrual History (just skip any sections that don't apply to you because of your age**):**

How old were you when you had your first period? _____
Describe your menstrual cycles (e.g. "about every 30 days, 5 days long, with 2 days heavy and the rest light, mild cramps on heavy days):
_____
_____
_____

If you are in menopause, at what age did your periods stop? _____
Are you having hot flashes or night sweats? none/ mild/ moderate/ severe (circle one)
Did you take hormone replacement therapy? Yes/ No
Are you having problems with vaginal dryness? Yes/ No Painful intercourse? Yes/ No

OB History

Please fill in details of any deliveries:

Date	Vaginal or C-section?	Baby's weight/gender/name (e.g. 7#12 oz female, "Mary")	Complications/Comments

Any miscarriages? _____ Abortions? _____ Tubal pregnancies? _____

Social History:

What is your occupation? _____
Marital Status (circle one): S M D W Separated Engaged
Name of spouse: _____
Tobacco use? Yes/ No How many cigarettes per day? _____
How many alcoholic beverages do you drink per week? _____
Use of street drugs? Yes/ No What type(s)? _____
Seat belt use? (Circle one) Always/ Usually/ Seldom/ Never
How many times a week do you exercise? _____
What activities do you do for exercise? _____
Do you usually wear sunscreen when spending time outside? Yes/ No
Do you feel safe at home? Yes/ No If the answer is "no," please explain why not:
_____
_____