# MEDICAL HISTORY FORM

Name: _____ Today's Date: __ _____

Date of Birth: _____ Provider: _____

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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
Migraine headache with aura
Migraines headache without aura
Thyroid Problems
Abnormal mammogram
Breast biopsy
Osteopenia or osteoporosis

Cancer Type(s): _____
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:

| Date | Type of Operation or Reason for Hospitalization | Details / Comments |
|---|---|---|
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What is the name of your family doctor, internist, or PCP? _____

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

_____
_____

List any medication, (prescriptions or over-the-counter), including vitamins and supplements you are taking now:

_____
_____
_____
_____
_____

**Health Maintenance:**

| | | |
|---|---|---|
| Date of last Pap Smear: | Results: | Location/Provider: |
| Date of last Mammogram: | Results: | Location/Provider: |
| Date of last Bone Density Study: | Results: | Location/Provider: |
| Date of last Colonoscopy: | Results: | Location/Provider: |
| Screening Lab Work: | Abnormal results: | |
| Circle any vaccines you have received and provide year given:<br>Flu vaccine / Shingles / Tdap / Gardasil | | |

**Family History:**

Please list any health problems in member 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? _____

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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 ever receive treatment for this? Yes / No
If "yes" what treatment was done? (freezing, laser, LEEP, cone biopsy)
Did you Paps go back to normal after the treatment? 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)
LNG-IUD (Mirena/Kyleena/Skyla/Lyletta) – When was it inserted? _____
Paragard IUD (copper) – When was it inserted? _____
Nexplanon – When was it inserted? _____
Condoms
Diaphragm

Name: _____ Date of Birth: _____

Tubal ligation
Essure
Partner has vasectomy
Natural family planning

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**:

How old were you when you had your first period?
_____

Describe your menstrual cycles (e.g. "about ever 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 have hormone replacement therapy? Yes / No
Are you having problems with vaginal dryness? Yes / No Painful intercourse? Yes / No

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**Obstetric History:**

Please fill in details of any deliveries:

| Date | Type of Delivery (vaginal or c-section) | Baby's weight | Gender | Name | Complications/Comments |
|---|---|---|---|---|---|
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Any miscarriages? _____ Abortions? _____ Tubal Pregnancies? _____

**Social History:**

What is your occupation? _____
Marital Status (circle one): Single Married Divorced Widowed 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 types(s)? _____
Seat belt use? (circle one) Always / Usually / Seldom / Never
How many times a week do you 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: _____
_____
_____