Patient Medical History (completed by the patient)

Name: _____ Date of birth: _____ Today's date: _____
Referred by:_____ Primary care MD: _____

GYNECOLOGIC HISTORY

Menstrual history:

Age periods began: _____ # of days from one period to next:_____ # of days of bleeding:
Age @ menopause: _____

Gynecologic problems: Have you ever had :

Abnormal pap smear	☐ Y	☐ N
Cervical/uterine polyps	☐ Y	☐ N
Uterine fibroids	☐ Y	☐ N
Ovarian cysts	☐ Y	☐ N
Endometriosis	☐ Y	☐ N
Tubal infection/pelvic inflammatory disease (PID):	☐ Y	☐ N
Sexually transmitted disease (STD) in past (circle) :	☐ Y	☐ N

GONORRHEA CHLAMYDIA SYPHYLIS HERPES
WARTS/CONDYLOMA/HUMAN PAPILLOMA VIRUS (HPV)

Infertility	☐ Y	☐ N
DES exposure	☐ Y	☐ N
Gynecologic cancer: type_____ Year_____	☐ Y	☐ N
Breast problem/biopsy	☐ Y	☐ N

Other GYN problem (SPECIFY) _____

Sexual/contraceptive history:

Are you currently sexually active? ☐ Y ☐ N
How many sexual partners have you had in your life? 0 1 2-4 >5
Age @ first intercourse: <16 yrs >16 yrs
What is your sexual orientation? HETEROSEXUAL HOMOSEXUAL BISEXUAL
Current birth control method: CONDOM DIAPHRAGM/CAP PILL IUD SPERMICIDE OTHER _____NONE
Past method(s): CONDOM DIAPHRAGM/CAP PILL IUD SPERMICIDE OTHER_____ NONE

Patient Medical History (page 2)

OBSTETRIC HISTORY

Total # of pregnancies: ___Full term:___ Preterm: ___Miscarriages:____ Abortions: ____ Living children: ___

Year	Weeks pregnant	Vaginal/forceps Vacuum/cesarean	Hrs in labor	Sex	Birth weight	Complications

PERSONAL PAST/PRESENT HISTORY OF ILLNESSES

High blood pressure	☐ Y	☐ N	High cholesterol	☐ Y	☐ N
Stroke	☐ Y	☐ N	Heart murmur	☐ Y	☐ N
Irregular heartbeat (arrhythmia)	☐ Y	☐ N	Heart attack	☐ Y	☐ N
Asthma	☐ Y	☐ N	Tuberculosis	☐ Y	☐ N
Reflux/gastric ulcer	☐ Y	☐ N	Bowel disease	☐ Y	☐ N
Gallbladder disease/stones	☐ Y	☐ N	Hepatitis/liver disease	☐ Y	☐ N
Kidney disease/stones	☐ Y	☐ N	Diabetes	☐ Y	☐ N
Thyroid disease	☐ Y	☐ N	Migraines	☐ Y	☐ N
Seizures/epilepsy	☐ Y	☐ N	Blood/bleeding disorder	☐ Y	☐ N
Blood clots/phlebitis in legs/lungs	☐ Y	☐ N	Arthritis/joint disease	☐ Y	☐ N
Autoimmune disease	☐ Y	☐ N	Bone disease/osteoporosis	☐ Y	☐ N
Skin disease	☐ Y	☐ N	Eye disease	☐ Y	☐ N
Cancer	☐ Y	☐ N	Injuries/fractures	☐ Y	☐ N

Depression/anxiety/other psychiatric disorder ☐ Y ☐ N

Have you ever had a blood transfusion? ☐ Y ☐ N

SURGICAL HISTORY HOSPITALIZATIONS

Year _____Type of operation_____ Reason_____

MEDICATIONS (including over-the-counter drugs, herbs, etc.) _____

_____

_____

ALLERGIES [ ] NONE MEDICATIONS_____ FOOD_____

Patient Medical History (page 3)

FAMILY HISTORY

Mother: LIVING ☐ DECEASED ☐ cause: age: _____ ***Father:*** LIVING ☐ DECEASED ☐ cause: age: _____

Siblings: # living: # deceased: causes/ages:

Children: # living: # deceased: causes/ages:

ANY SIGNIFICANT Family history of illnesses :(*blood relatives,* including immediate family, grandparents, aunts/uncles, cousins) :

High blood pressure ☐ Y ☐ N _____
High cholesterol ☐ Y ☐ N _____
Stroke ☐ Y ☐ N _____
Heart attack ☐ Y ☐ N _____
Asthma ☐ Y ☐ N _____
Tuberculosis ☐ Y ☐ N _____
Kidney disease/stones ☐ Y ☐ N _____
Diabetes ☐ Y ☐ N _____
Thyroid disease ☐ Y ☐ N _____
Seizures/epilepsy ☐ Y ☐ N _____
Bleeding disorder ☐ Y ☐ N _____
Blood clots/phlebitis ☐ Y ☐ N _____
Breast Cancer ☐ Y ☐ N _____
Ovarian Cancer ☐ Y ☐ N _____
Depression/anxiety/other psychiatric disorder ☐ Y ☐ N _____

SOCIAL HISTORY

Marital status: ☐ MARRIED ☐ LIVE w/ PARTNER ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐
Highest level of school completed: ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE ☐
Occupation: _____
Ethnicity: _____
Have you ever smoked? ☐ Y ☐ N # of packs per day_____ # of years: _____
Do you currently smoke? ☐ Y ☐ N
Do you drink alcohol? ☐ Y ☐ N # of drinks per day_____ # of drinks per week:_____
Do you use recreational drugs? ☐ Y ☐ N _____
Have you ever been abused or threatened by anyone? ☐ Y ☐ N _____
Do you exercise regularly? ☐ Y ☐ N # of times per week: _____

Patient signature _____ DATE: _____

MD signature _____