

PATIENT'S MEDICAL HISTORY

NAME: _____
(last) (first)

DATE: _____
AGE: _____ DOB: _____

MENSTRUAL HISTORY:

Age Began: _____ Frequency: _____ Last Menses: _____

Do you have problems with menses: _____ Details: _____

CONTRACEPTION:

What method are you currently using? _____

Have you ever used: Pills _____ Diaphragm: _____ I.U.D.: _____

OBSTETRICAL HISTORY:

Year & Hospital	Sex	Weight	Doctor	Problems with prenatal care or delivery?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

MISCARRIAGES OR ABORTIONS:

Year	Hospital	Doctor	Problems
_____	_____	_____	_____
_____	_____	_____	_____

GYN SURGERY:

Year	Hospital	Doctor	Operations	Problems
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

GENERAL SURGERY:

Year	Hospital	Doctor	Operations	Problems
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SOCIAL HISTORY: Tobacco: How much per day: _____

Alcohol: None: _____ Mild: _____ Heavy: _____

Drug Abuse? _____

Are you a victim of physical or mental abuse? ___ Yes ___ No

SEXUALLY TRANSMITTED DISEASE: _____

Condylomata (Venereal Warts): _____ Chlamydia _____ Herpes _____

Possible exposure to AIDS: _____ Pelvic Inflammatory Disease (P.I.D.) _____

History of HPV _____ Abnormal Paps _____

NAME: _____

DOB: _____

MEDICAL HISTORY: (DO YOU HAVE OR HAVE YOU EVERY HAD) IF SO, GIVE DETAILS

HEART DISEASE (High Blood Pressure) _____

LUNG DISEASE (Asthma): _____

INTESTINAL: _____

URINARY TRACT: _____

MUSCULAR SKELETAL: _____

PSYCHIATRIC OR EMOTIONAL: _____

ENDOCRINE (DIABETES/THYROID): _____

CANCER: _____

TRANSFUSIONS: HAVE YOU EVERY HAD? _____ DETAILS: _____

ALLERGIES: _____ TO WHAT DRUGS? _____

MEDICATIONS NOW? _____ (FOR WHAT DIAGNOSIS) _____

FAMILY HISTORY:

RELATIONSHIP

Breast Cancer: _____

Uterine Cancer: _____

Ovarian Cancer: _____

Mother: _____ **Sister:** _____ **Grandmothers:** _____

MAMMOGRAPHY:

Ever Done: _____ **Year:** _____ **Results** _____

Bone Density _____ **Colonoscopy** _____ **Colon Cancer** _____

POST MENOPAUSAL PATIENTS:

Year Menses Ceased? _____

Problems with menopause? (Bleeding, Flushes, Etc.)

REASON FOR YOUR VISIT TODAY: DETAILS: _____

WOULD YOU LIKE THE NURSE TO BE PRESENT DURING YOUR EXAMINATION?

Yes _____ No _____

DO NOT WRITE BELOW THIS LINE

