

Patient History

NAME: _____

Date of Birth: ___/___/___

S E M Sep D W

Today's Date: ___/___/___

My age today: _____ yrs

Current Medical History

List medical problems you are currently being treated for? _____

What have you been hospitalized for? _____

List Surgeries you have had: _____

List Drug Allergies (include reaction): _____

List medications you take regularly: _____

Past Medical History: Have **you** ever had?

- High blood pressure
- Heart disease
- Mitral valve prolapse
- Elevated cholesterol
- Stroke
- Diabetes
- Asthma or other lung disease
- Thyroid disorder
- Migraines or other type of headache
- Liver or gallbladder disease
- Hepatitis A, B, or C
- Sickle cell, thalassemia
- Any other blood disorder
- DVT or phlebitis
- Kidney or bladder disease
- Chronic urinary tract infections
- Seizures or other neurologic disorder
- Vision or hearing problems
- Depression, anorexia, bulimia
- Psychiatric disorder
- Endometriosis
- Uterine fibroids
- Pathologic ovarian cysts
- Breast lumps / nipple discharge

Family History: Has **any close relative** ever had?

- Breast cancer
- Ovarian cancer
- Cervical / uterine cancer
- Colon cancer
- Osteoporosis
- Diabetes
- Hypertension
- Heart disease
- Stroke
- Sickle cell / Thalassemia
- Tay Sachs
- Inheritable genetic disorder

Social History:

Do you smoke? Yes No

cigarettes / day: _____

Do you drink? Yes No

#drinks / day: _____ #drinks / week: _____

Do you think you drink too much? Yes No Maybe

Do you now or have you had an eating disorder? Yes No

Exercise (Type / Duration / Frequency): _____

Diet: _____

Gynecologic / Obstetric History:

Age when periods began: _____. Age when they stopped (if in menopause) _____

Period comes every ____ days and lasts ____ days Has there been a change in your periods recently? Yes No

Painful periods? None Mild Moderate Severe Incapacitating Medications used: _____

Do you have PMS? None Mild Moderate Severe

What are your symptoms? _____ How do you treat them? _____

Date of your last pelvic / PAP exam: ___/___/___

Date of your last Mammogram ___/___/___

Have you ever had an abnormal PAP smear? Yes No.

If so, how was it treated? _____

Have you ever had:

- Venereal warts / Condyloma / HPV
- Gonorrhea / Chlamydia
- Trichomonas
- Pelvic Inflammatory Disease
- Herpes
- Other

Are you currently sexually active? Yes No Number of sexual partners in the last year: ____ last 5 years: _____

Do you have pain with intercourse? Yes No What method of contraception are you using? _____

Have you ever been pregnant? Yes No

How many times pregnant? _____ Number of: Full Term _____ Premature _____

Dates of pregnancies: _____ Miscarriages _____ Stillbirths _____

How old are your children? _____ Ectopic preg. _____ Abortions _____