

MEDICAL HISTORY FORM FOR NEW PATIENTS

Name: _____ Age: _____ Date: _____

Please answer these questions about your previous and current health. We will review these with you.

Reason for visit:

Date and Place of last Pap:

Date & Place of last Mammogram:

Name of Primary Care Physician:

Past Gynecological History: *Please check off any conditions that you have had and give dates if appropriate*

Gynecological Illness	Yes	Date	Gynecological Illness	Yes	Date
Pelvic Inflammatory Disease			Fertility Problems		
Ovarian Cysts			Sexually Transmitted Infections		
Uterine Fibroids			Abnormal Pap Smears or HPV infection		
Endometriosis			DES Exposure		
Breast Disease			Polycystic Ovarian Disease		
Chronic Pelvic or Vulvar Pain			Other		

Menstrual History:

Age at First Menses:	Date/Age of Last Menstrual Period:
Usual Interval Between Period:	Usual days of Bleeding with Each Period:
Cramping with Period?	Heavy Bleeding?
Bleeding Between Periods?	
Need for Pain Medication (please list):	

Miscarriage(s):

Termination(s) of Pregnancy:

Use of Contraception: *(Please check the appropriate response)*

	<i>Dates</i>		<i>Dates</i>
Birth Control Pills/type		Fertility Awareness	
Diaphragm		IUD/type	
Condoms		Cervical cap/Other	

Sexual History/Orientation: *Please write in (or speak to your provider) about any information or concerns you would like for her to know.*

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Have you ever been a victim of rape, incest, domestic violence or sexual abuse?

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Pregnancies:

Year	Type of Delivery	Birth Weight of Infant	Complications

Past Surgical Procedures (Including Non-Gynecologic)

Year	Procedure	Reason For Procedure

Past Medical History: *Please check any that you have had and give dates..*

Past Medical Problems	Yes	Date	Past Medical Problems	Yes	Date
Rheumatic Fever			Hepatitis		
Asthma			HIV Infection		
Epilepsy			High Blood Pressure		
Heart Disease			Bleeding/ Clotting Disorders		
Mitral Valve Prolapse			Anemia		
Tuberculosis			Diabetes		
Eating Disorder			Gastrointestinal Problems		
Kidney Problems			High Cholesterol		
Thyroid Abnormalities			Depression		
Osteoporosis			Other Psychological Problems		
Arthritis			Bone Density		
Lupus			Colonoscopy		
Other			Other		

Medications: *Please list all current*

Prescription Medications	Dosage
Over-the-Counter Medications	
Herbal Supplements/Vitamins	
Gardasil Vaccine	Dates

Allergies: *Please check and state type of reaction.*

Penicillin	Shellfish:
Sulfa Medications	Other:
Iodine	Other:

Occupation:

Please describe your usual diet:

<i>Caffeine?</i>	
<i>Do you smoke? Yes <input type="checkbox"/> /No <input type="checkbox"/> /Quit <input type="checkbox"/></i>	<i>How many packs per day? _____ How many years? _____</i>
<i>How many alcoholic drinks per weeks?</i>	
<i>Other recreational drug use?</i>	<i>History of substance abuse?</i>

Exercise:

Do you engage in regular exercise? Yes <input type="checkbox"/> / No <input type="checkbox"/>
Please describe:

Family History: *Do/Did any family members have any of the following?*

	<i>Relationship</i>	<i>Age</i>		<i>Relationship</i>	<i>Age</i>
Breast Cancer			Osteoporosis		
Colon Cancer			Prostate Cancer		
Ovarian Cancer			Pancreatic Cancer		
Uterine Cancer			Heart Attack (under age 65)		
Phlebitis/Clotting/Bleeding Problems			High Blood Pressure		
Diabetes			Thyroid Disease		
Melanoma			Other Cancers		

Please list any other health information that you would like to discuss:

FOR PHYSICIAN USE ONLY

NOTES:

Age:

Weight:

Height:

BP:

LMP:

UA:

HCG: