MEDICAL HISTORY

THIS INFORMATION IS CONFIDENTIAL

(If you do not understand any of the questions or terms used in this form, please let us know)

Date:_____ Name:_____ Race:_____

Date of Birth:_____ Age:_____ Occupation:_____

Are you allergic to any medications? ❑ YES ❑ NO If yes, which medications?_____

Please list all medications you are currently taking, including laxatives._____

_____

List any supplements or herbs used_____

MENSTRUAL HISTORY

First day of last menstrual period:_____ Age first period started:_____ Do you have bleeding between periods? ❑ YES ❑ NO

The following questions are about your menstrual cycle when you are not taking birth control pills:

How often do you menstruate? Every _____ days.

Regular cycles? ❑ YES ❑ NO How long do your periods last?_____ days.

Cramps: ❑ None ❑ Moderate ❑ Severe Number of pads or tampons used on heaviest day_____

GYNECOLOGIC HISTORY: Have you ever had any of the following? (Check if yes)

❑ Recurrent vaginal infections
❑ Gonorrhea/Chlamydia/Syphilis
❑ Herpes
❑ Condylomata (Genital Warts) HPV
❑ Infection of pelvic organs (PID)
❑ Cryosurgery or conization of cervix or LEEP procedure
Date of last pap smear_____
History of abnormal pap smears? ❑ YES ❑ NO
❑ Abnormal Pap – Date of last Abnormal Pap_____
❑ Surgery on your female organs

❑ Difficulty holding urine
❑ Pain with intercourse
❑ Abnormal vaginal bleeding
❑ Premenstrual Syndrome (PMS)
❑ Endometriosis
❑ Infertility
❑ Fibroids
❑ Prolapse
❑ PCOS
❑ Other

Do you have more than one sexual partner? ❑ YES ❑ NO Have you recently changed partners? ❑ YES ❑ NO

How long have you been with your current sexual partner(s)?_____

Did your mother take DES (a hormone to prevent miscarriage) when she was pregnant? ❑ YES ❑ NO ❑ Don't Know

CONTRACEPTIVE HISTORY: Check the methods you have used.

Past	Present	Past	Present	Past	Present
❑	❑ Pills	❑	❑ Condoms	❑	❑ Natural Family Planning
❑	❑ IUD	❑	❑ Foam/Spermicide	❑	❑ Tubal Ligation
❑	❑ Diaphragm	❑	❑ Hormone Ring/Patch	❑	❑ Vasectomy
❑	❑ DepoProvera	❑	❑ Norplant	❑	❑ Other

PREVIOUS PREGNANCIES:

Summarize pregnancies: FULL TERM_____ PREMATURE_____ ABORTION/MISC._____ NOW LIVE_____ MULTI. BIRTHS_____

Please give all the information in regard to your previous pregnancies by filling in the spaces below. If information is unknown, leave space blank. (Include Miscarriages)

NO.	YEAR	PLACE OF DELIVERY AND CONFINMENT	DURATION OF PREG.	DURATION OF LABOR	TYPE OF DELIVERY	BORN ALIVE?	INFANT BIRTH WEIGHT	MATERNAL COMPLICATIONS	CHILD COMPLICATIONS	BOY OR GIRL
1										
2										
3										
4										
5										

FAMILY HISTORY: Have your parents, brothers, or sisters ever had any of the following? (Check if yes)

- ❑ Heart problems
- ❑ Thyroid problems
- ❑ Stroke or paralysis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Blood Clots/Clotting Disorder
- ❑ Genetic conditions, birth defects, or inherited bleeding disorders
- ❑ Diabetes
- ❑ Cancer
- ❑ Asthma or tuberculosis
- ❑ Alcoholism or drug dependency
- ❑ Depression/psychiatric illness
- ❑ Osteoporosis
- ❑ Jaundice, hepatitis, or liver problems

MEDICAL HISTORY: Have you ever had any of the following? (Check if yes)

- ❑ Genetic conditions or birth defects
- ❑ High blood pressure
- ❑ Heart disease
- ❑ Blood clots
- ❑ High Cholesterol
- ❑ Stoke or paralysis
- ❑ Cancer
- ❑ Frequent severe headaches
- ❑ Epilepsy or convulsions
- ❑ Diabetes/Insulin Resistance
- ❑ Gastrointestinal problems (i.e. ulcers, colitis, etc.)
- ❑ Liver problems (i.e. jaundice, mono)
- ❑ Hepatitis (A, B or C)
- ❑ Gall Bladder problems
- ❑ Lung problems (i.e. asthma, bronchitis, pneumonia)
- ❑ Thyroid problems
- ❑ Anemia
- ❑ Bleeding problems
- ❑ Blood transfusions
- ❑ Psychiatric care/Depression
- ❑ Alcoholism or drug dependency
- ❑ Recurrent bladder infections
- ❑ Kidney infections
- ❑ Breast problems
- ❑ Osteoporosis
- ❑ Positive TB test_____ (date)
- ❑ Treated for TB_____(date)
- ❑ History of bone fracture as an adu
- ❑ Arthritis/ Fibromyalgia

REVIEW OF SYSTEMS: Are you currently having problems with:

- ❑ Chest pain/irregular heart beat
- ❑ Abdominal or pelvic pain
- ❑ Heart disease
- ❑ Nausea/vomiting
- ❑ Ears/nose/sinus
- ❑ Weight change
- ❑ Dizziness/Headache
- ❑ Muscles/joint
- ❑ Breathing
- ❑ Bowel changes
- ❑ Bladder/urine leakage
- ❑ Anxiety/nerves/depression
- ❑ Chronic cough
- ❑ Bloody sputum
- ❑ Other

Please list all the times you have been hospitalized (excluding childbirth) – surgery or illness

DATE	LENGTH OF STAY	ILLNESS OR OPERATION	ANESTHESIA	COMPLICATIONS

Do you consider your diet ❑Good ❑Fair ❑Poor On special diet? ❑YES ❑ NO If yes, what type?_____

What type of regular exercise?_____

Do you smoke cigarettes? ❑ YES ❑ NO Number per day _____

Do you drink alcohol? ❑ YES ❑ NO Number of drinks per day _____

Other recreational drugs? ❑ YES ❑ NO What types?_____

Do you intake adequate calcium (2-3 servings of dairy per day)? ❑ YES ❑ NO

MARITAL HISTORY:

❑ Single ❑ Married ❑ Separated ❑ Widowed ❑ Divorced ❑Partnered

Partner Name_____ Age_____ Health_____

Occupation_____

Signature of Provider_____ _____