

Women's Medical History

Name: _____

Marital status: S M W D Sep

Age: _____ Today's date: _____

Occupation: _____ Employer: _____ Referred by: _____

Reason for Seeing the Doctor Today (more room on last page)

Obstetrical and Gynecologic History

Obstetrical History	Total Number of Pregnancies _____	Complications of Pregnancy:
	No. of Term Births _____	<input type="checkbox"/> Diabetes
	No. of Pre-Term Births _____	<input type="checkbox"/> High blood pressure
	No. of Miscarriages _____	<input type="checkbox"/> C-section
	No. of Abortions _____	<input type="checkbox"/> Toxemia
	No. of Ectopic Pregnancies _____	<input type="checkbox"/> Other: _____
	No. of Living Children _____	

Contraceptive History: check all birth control methods you have used

Natural Family Planning or Rhythm Method	<input type="checkbox"/> Now	<input type="checkbox"/> Ever	Complications: _____
Spermicide/Foam	<input type="checkbox"/> Now	<input type="checkbox"/> Ever	_____
Condoms	<input type="checkbox"/> Now	<input type="checkbox"/> Ever	_____
Diaphragm	<input type="checkbox"/> Now	<input type="checkbox"/> Ever	_____
Oral Contraceptives (birth control pills)	<input type="checkbox"/> Now	<input type="checkbox"/> Ever	_____
Depo-Provera Injections	<input type="checkbox"/> Now	<input type="checkbox"/> Ever	_____
Norplant	<input type="checkbox"/> Now	<input type="checkbox"/> Ever	_____
IUD	<input type="checkbox"/> Now	<input type="checkbox"/> Ever	_____
Tubal Ligation	<input type="checkbox"/> Now	<input type="checkbox"/> Ever	_____
Vasectomy of Partner	<input type="checkbox"/> Now	<input type="checkbox"/> Ever	_____
Other	<input type="checkbox"/> Now	<input type="checkbox"/> Ever	_____

Sexual Are you currently sexually active? Yes No If yes, number of partners: last year ____; ever ____

If no, have you ever been? Yes No

Are you: Heterosexual Homosexual Bisexual

GYN History Age of first menstruation _____ Date of last normal menstrual period _____

Interval between periods _____ (number of days from first day of bleeding to first day of next period)

How many days do you bleed? _____ Usual number of pads/tampons on heaviest day _____

Cramps? None Mild Moderate Severe

If menopause, year began? _____ Any bleeding since? Yes No N/A

Have you ever had an abnormal PAP test? Yes No

Have you ever had a colposcopy or biopsy? Yes No

Do you bleed between your periods? Yes No

Were you exposed to diethylstilbestrol (DES) before birth? Yes No

Do you experience pain with intercourse? Yes No

Do you experience bleeding after intercourse? Yes No

Do you experience pain between periods? Yes No

Are you currently experiencing vaginal discharge? Yes No

Are you currently experiencing vaginal itching or discomfort? Yes No

Have you experienced prolapse of bladder uterus or bowel? Yes No

Have you experienced leakage from bladder or bowel? Yes No

Place sticker Here Sideways

Do you presently have, or have you had, these problems?	Current	Past	
Fibroids/myomas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No
Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No
Infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No
Gonorrhea or chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No
Genital warts/HPV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No
HIV or AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No
Trichomoniasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No
Bacterial vaginosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No
Yeast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No
Pelvic inflammatory disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No

Current Medications (name of the drug and the dosage):

1. _____	5. _____	Do you take any: <input type="checkbox"/> Herbal products <input type="checkbox"/> Vitamins <input type="checkbox"/> Minerals
2. _____	6. _____	
3. _____	7. _____	
4. _____	8. _____	

Drug Allergies (Please check or list all drugs and type of reaction): I am not allergic to any medications

Codeine reaction _____ Penicillin reaction _____ Sulfa reaction _____
 Other _____ reaction _____ Other _____ reaction _____

Medical Problems: Have you had (or do you have now) any of the following medical problems?

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Ovarian cancer	<input type="checkbox"/> Asthma	<input type="checkbox"/> Neck surgery or irradiation
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Colon cancer	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Urinary tract infection
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Skin cancer	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other kidney disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other cancer	<input type="checkbox"/> Sickle cell	<input type="checkbox"/> Colitis or irritable bowel
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Anemia	<input type="checkbox"/> Received blood transfusion
<input type="checkbox"/> Uterus cancer	<input type="checkbox"/> Hepatitis or jaundice	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Phlebitis or blood clots
<input type="checkbox"/> Cervix cancer	<input type="checkbox"/> Liver/pancreas disease	<input type="checkbox"/> Ulcer disease	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Breast cancer	<input type="checkbox"/> Lupus	<input type="checkbox"/> Gallbladder disease	

Health Maintenance: **Month and Year** **Result Normal (if known)?**

Health Maintenance:	Month and Year	Result Normal (if known)?	
Pap test		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cholesterol (if over 30)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mammogram (if over 40)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sigmoidoscopy (if over 50)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stool test for blood (if over 50)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bone density (if over 65)		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Past Surgery: Have you had any of the following operations? If so, what year?

Appendix _____ year Gall bladder _____ year Thyroid _____ year Hysterectomy _____ year
 Hernia _____ year Heart _____ year Lung _____ year Spine/joint _____ year
 Tonsils _____ year Other (describe) _____

Hospitalizations: List any hospitalizations other than surgeries listed above or childbirth.

Year	Reason	Year	Reason

Immunizations: Please enter information about immunizations you have had:

Hepatitis A..... Yes No
 Pneumonia Yes No
 Chicken pox..... Yes No
 Hepatitis B Yes No
 Rubella..... Yes No
 If born after 1957, have you received a second measles vaccination? Yes No
 Influenza (flu): _____ (yr); Tetanus: _____ (year)
 Tuberculosis skin test: _____ (yr) TB test positive? Yes No

Social History:

Highest level of education: _____ If married, how long? _____ years. How many previous marriages have you had? _____

Who currently lives in household? _____

Do you regularly exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you regularly wear a seat belt?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you regularly use sun block?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have regular eye exams?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have regular dental exams?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you examine your breasts regularly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you smoke cigarettes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Total years smoking? _____
Have you ever smoked cigarettes?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when did you quit? _____
Do you use other tobacco products?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Which one(s)? _____
Do you drink alcohol?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, drinks per week? <input type="checkbox"/> 1-7; <input type="checkbox"/> 8-14; <input type="checkbox"/> over 14
Have you ever used illicitdrugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever been physically abused or hurt?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, in the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever been forced to have sexual activity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, in the past 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are there firearms in your home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you wish to be tested for HIV?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Family History: For blood relatives only, check if any relative had any of the following diseases.

For parents and grandparents, please enter the current age if living, or age at the time of death if deceased.

	Living?	Age	High Blood Pressure	Heart Disease	Diabetes	Colon Cancer	Breast Cancer	Other Cancer	Other Problems (describe)
Father	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grandfather	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grandmother	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mother	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grandfather	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grandmother	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Any Sibling			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Other diseases in your family:

<input type="checkbox"/> Stroke	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Asthma
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Sickle cell	<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Psychiatric problems
<input type="checkbox"/> Leukemia or lymphoma	<input type="checkbox"/> Other _____		

Review of Systems: Are you presently having any of the problems outlined below?

General:	Weight gain or loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Loss of appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Fever or night sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Marked fatigue, dizziness or weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Skin	Skin problems or rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Moles that have changed color or size	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Breast	Breast pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	1 - 3 - 5 - 7 - - 10
	Nipple discharge	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Breast lump	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Change in breast	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Past breast surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Abnormal mammogram	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Eyes	Wear glasses or contact lenses	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Blurred vision or visual disturbances	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Ears	Ringing in your ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Ear discomfort	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Trouble hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Nose	Nosebleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Nasal congestion/drainage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Sinus infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Mouth & Throat	Dental problems/dentures/tooth pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Mouth sores	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Sore throat or hoarseness (other than colds)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Difficulty swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Current Primary Care Physician

Name	Specialty	City, State	Approximate date of last visit

Your Last OB/GYN Physician

Name	Specialty	City, State	Approximate date of last visit

Please list other physicians you are currently seeing

Name	Specialty	City, State	Approximate date of last visit

Do you have any medical problems or additional concerns not mentioned above?

Advanced Directives: Do you have a living will or medical durable power of attorney?

I have a living will. I have signed a medical durable power of attorney. I'm interested in learning about these.

Your Signature (or person completing form): _____ Date _____

