Medical History Form

Name:	DOB: / /	Date:
LIMITATION TO CARE: ☐ Disability:		
Translator Needed: ☐ Spanish ☐ American Sign Language ☐ Other:		
Other Preferences:		

CURRENT MEDICATIONS: List all Current and Over the Counter Medications

MEDICAL HISTORY: Select all that apply

☐ Alcohol Abuse ☐ Anemia ☐ Anxiety Depression ☐ Arthritis ☐ Autoimmune Disorder ☐ Blood Transfusion ☐ Breast Problems ☐ Cholesterol ☐ Clotting Disorder ☐ Diabetes	☐ DVT/PE ☐ Eating Disorder ☐ Endometriosis ☐ Fibroids ☐ GI Issues ☐ Heart Disease ☐ Hepatitis/Liver Disease ☐ High Blood Pressure ☐ Kidney Disease	☐ Kidney Stones ☐ Lung Problems ☐ Migraine Headaches ☐ Osteoporosis ☐ Polycystic Ovarian Syndrome ☐ Stroke ☐ Substance Abuse ☐ Thyroid Disease ☐ Other: Please Specify _____	☐ Breast Cancer ☐ Cervical Cancer ☐ Colon Cancer ☐ Endometrial Cancer ☐ Ovarian Cancer ☐ Rectal Cancer ☐ Uterine Cancer ☐ Other: Please Specify _____

ALLERGIES: List All Known Drug Allergies

☐ No Known Drug Allergies		

GYN HISTORY

GYN Testing: answer all that apply

▪ Last Pap Smear	/ /
▪ Result of Last Pap Smear [ ] Normal [ ] Abnormal [ ] No pap ever	
▪ Last HPV Testing	/ /
▪ Last Colposcopy	/ /
▪ Last Mammogram	/ /
▪ Last Pelvic Ultrasound	/ /
▪ Last Colonoscopy	/ /
▪ Date of Last Bloodwork	/ /

MENOPAUSE: if menopausal

▪ Began at age:	years old

▪ **Current Menopausal Symptoms**:
[ ] None [ ] Hot Flashes [ ] Memory Loss
[ ] Headache [ ] Irritability [ ] Weight Gain
[ ] Loss of Libido [ ] Vaginal Dryness
[ ] Other: please specify

▪ **Treatment:** [ ] None [ ] Hormone [ ] OTC

SELF-BREAST EXAMINATION

▪ **Do you perform Self-Breast examinations?**
[ ] Monthly [ ] Sometimes [ ] Do not perform

MENSTRUATION: if menopausal skip

▪ **Age of Onset:** At what age did your periods start?	yrs old
▪ **LMP:** What was the date of your last period?	/ /

▪ **Time Between Periods:**
[ ] Irregular [ ] 21-32 days apart [ ] < 21 days apart
[ ] 33-44 days apart [ ] > 45 days apart

▪ **Duration:** How long does your period last?
[ ] < 7 days [ ] 2-7 days [ ] 3 days

▪ **Pad or Tampon use per day:**
[ ] 1-3 per day [ ] 4-6 per day [ ] 7 + per day

▪ **How would you describe your period?**
With: [ ] severe pain [ ] mild discomfort [ ] moderate pain
[ ] without moderate pain [ ] light [ ] heavy

MENSTRUAL SYMPTOMS: select all that apply

[ ] None [ ] Headaches [ ] Bloating [ ] Irritability
[ ] Migraines [ ] Weight Gain [ ] Mood Swings [ ] Nausea

▪ Cramping : [ ] Mild [ ] Moderate [ ] Severe

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BIRTH CONTROL: please specify

☐ None	☐ Nexplanon	☐ Nuva Ring	☐ Kyleena IUD
☐ Condoms	☐ Diaphragm	☐ Bilateral Tubal Ligation	☐ Liletta IUD
☐ Depo Provera	☐ Ortho Evra Patch	☐ Vasectomy	☐ Mirena IUD
☐ Oral Contraceptives	☐ Spermicide	☐ Withdrawal method	☐ Paragard IUD
			☐ Skyla IUD

SEXUAL ACTIVITY: please specify

☐ Currently sexually active		☐ Not currently sexually active	
▪ Age of first sexual activity	years old	▪ Total # of Lifetime Partners	please specify: _____

Currently or in the past, I have had sex with: [ ] Men [ ] Women [ ] both, Men and Women

Have you been trying to get pregnant without success? ☐ Yes ☐ No

SEXUALLY TRANSMITTED INFECTIONS (STI'S): please specify

[ ] None [ ] Human Papilloma Virus (HPV) [ ] Chlamydia [ ] Herpes Simplex Virus (HSV) [ ] Gonorrhea [ ] Syphilis
[ ] Trichomoniasis [ ] Hepatitis B [ ] Hepatitis C [ ] Human Immunodeficiency Virus (HIV)

URINARY INCONTINENCE

Do you ever leak urine you cough, sneeze, laugh, or exercise?	☐ Yes	☐ No
Do you ever leak urine on the way to the bathroom or can't get to the bathroom on time?	☐ Yes	☐ No
Do you go to the bathroom frequently more than seven times a day and/or get up more than two times at night?	☐ Yes	☐ No

Other:

OB HISTORY

Total # of Pregnancies		Total Living Children	
Number of full-term pregnancies (37 weeks or greater)		Number of preterm Pregnancies (less than 37 weeks)	
Number of Miscarriages/Abortions		Number of Ectopic (tubal) Pregnancies	

Please fill out the following to the best of your recollection regarding your prior pregnancies:

	Date MO/YEAR	SEX	GA WEEKS	TYPE of DELIVERY	BIRTH WEIGHT	ANESTHESIA	LENGTH of LABOR	WEIGHT GAIN
Preg 1		M F		Vaginal C-Section	lbs. oz.			
Comments and complications:								
Preg 2		M F		Vaginal C-Section	lbs. oz.			
Comments and complications:								
Perg 3		M F		Vaginal C-Section	lbs. oz.			
Comments and complications:								
Preg 4		M F		Vaginal C-Section	lbs. oz.			
Comments and complications:								

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SURGICAL HISTORY: In Date Order, please list all surgeries and c-sections (including minor surgery)

☐ Denies Past Surgical History

Mo/Year	Type of Surgery

HOSPITALIZATION: Please list any hospitalization

☐ Denies any Hospitalization ☐ See Surgical History Above

Mo/Year	Please Specify:

FAMILY HISTORY: Please check all that apply for the corresponding family members by placing an "**X**" in the appropriate boxes.

☐ **Patient Adopted**

	Heart	Diabetes	Hypertension	Breast	Ovarian	Heart	Colon	Stroke	Mental Illness
Mother									
Father									
Maternal Grandmother									
Maternal Grandfather									
Paternal Grandmother									
Paternal Grandfather									
Daughter									
Son									
Sister									
Brother									

List all other Family Genetic Disorder(s) and specify the relationship:

SOCIAL HISTORY

Tobacco: Are you a Tobacco Smoker? ☐ Non-Smoker ☐ Yes, Current Smoker ☐ Former Smoker

If *yes*, please answer the following:

How often do you smoke cigarette's? ☐ Everyday ☐ Somedays, but not everyday

If "current smoker": How many cigarettes a day do you smoke?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

Are you interested in quitting? ☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

Non-Tobacco Use: I am *not* using tobacco, but I am currently:

☐ using an E-Cigarette ☐ Vaping ☐ using Marijuana

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SOCIAL HISTORY

Alcohol:

- Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No
- If yes, how often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2-4 times a month
☐ 2-3 times a week ☐ 4 or more times a week

Drugs

- Have you used drugs other than those for medical reasons in the past year? ☐ Yes ☐ No
- **If yes, please select all that applies:**

☐ Heroin ☐ PCP ☐ Prescription Opiates ☐ LSD
☐ Cocaine ☐ Ketamine ☐ Ecstasy ☐ Crack
☐ Marijuana ☐ Methamphetamine

- If yes, How many months ago did you use? [_____] months ago
- Are you in a treatment program? ☐ Yes ☐ No
- Have you ever injected drugs? ☐ Yes ☐ No
- Are you still using? ☐ Yes ☐ No
- Is there a minor 18 years or younger at home? ☐ Yes ☐ No
- How many children at home under 18 years old? ☐ Yes ☐ No

Miscellaneous:

Occupation:

Please describe Caffeine Intake:

☐ None ☐ 1-2 cups per day ☐ 2-3 cups per day
☐ 3-4 cups per day ☐ More than 4 cups per day

Any history of domestic violence?

☐ None ☐ History in the past ☐ Has restraining order
☐ Feels unsafe at home ☐ Have safety plan

Any history of verbal abuse?

☐ None ☐ Occasional ☐ Frequent
☐ Seeking Counseling ☐ Has safety plan

- Has your partner ever threatened you or made you feel afraid? ☐ Yes ☐ No
- Does your partner or someone important to you hurt you physically or emotionally? ☐ Yes ☐ No

IMMUNIZATIONS: Have you had any of the following?

Chicken Pox	☐ Yes	☐ No	Year	Hepatitis B	☐ Yes	☐ No	Year
DTAP	☐ Yes	☐ No	Year	Pneumonia	☐ Yes	☐ No	Year
Flu	☐ Yes	☐ No	Year	Rubella	☐ Yes	☐ No	Year
Gardasil	☐ Yes	☐ No	Year	Tetanus	☐ Yes	☐ No	Year

Would you object to blood products in the event of an emergency?

- Choose one: ☐ No, I will not object to blood products. ☐ Yes, I will object to blood products.

Patient Name: (please print)	Date
Patient Signature:	