

# PATIENT HISTORY

PATIENT NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_/\_\_\_/\_\_\_\_ TODAY'S DATE: \_\_\_/\_\_\_/\_\_\_\_

DATE OF LAST MENSES: \_\_\_/\_\_\_/\_\_\_\_

COMPLAINT (State reason you want to see doctor.): \_\_\_\_\_

## MEDICAL HISTORY:

### Illnesses/Medical Problems:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Operations/Surgery (Hysterectomy, Tubal Ligation, Cesarean Section):

\_\_\_\_\_  
\_\_\_\_\_

### GYN Hx:

Age at 1st Menses: \_\_\_\_\_

Are menses regular?  Yes  No

How many days does menses last? \_\_\_\_\_

History of STI: Chlamydia, Gonorrhea, Trichomonas, Herpes, Genital Warts, Syphilis, Hepatitis, etc.

Yes  No If yes, please list: \_\_\_\_\_

Date of Last Pap Smear: \_\_\_/\_\_\_/\_\_\_\_

Any abnormal pap smears?  Yes  No \_\_\_\_\_

When? \_\_\_\_\_

Form of Contraception: \_\_\_\_\_

### Medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Drug/Food Allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Pregnancy History:

No. of Pregnancies: \_\_\_\_\_ No. of Miscarriages: \_\_\_\_\_

No. of Living Children: \_\_\_\_\_ Largest Baby Wt.: \_\_\_\_\_

No. of Pre-term Deliveries: \_\_\_\_\_

Complications: \_\_\_\_\_

### Immunizations: (Up-To-Date)

Yes  
 No

## REVIEW OF SYMPTOMS

Check any items you may have problems with:

<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Stomach	<input type="checkbox"/> Kidney/Bladder
<input type="checkbox"/> Stroke	<input type="checkbox"/> Asthma/Lung	<input type="checkbox"/> Liver	<input type="checkbox"/> Joint Pain
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart/Blood Pressure	<input type="checkbox"/> Bowel	<input type="checkbox"/> Skin Rashes

## FAMILY HISTORY

Check any illness your immediate family member (father, mother, brother, sister) may have or had:

<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Uterine Cancer	<input type="checkbox"/> Ovarian Cancer
<input type="checkbox"/> Cervical Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease Before Age 60
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Other: _____

## SOCIAL HISTORY

Check and/or complete as indicated:

SMOKING: Packs Per Day: \_\_\_\_\_ How many years? \_\_\_\_\_ ALCOHOL: Ounces Per Day: \_\_\_\_\_ How many years? \_\_\_\_\_

MARITAL STATUS: SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ DIVORCED \_\_\_\_\_ SEPARATED \_\_\_\_\_ WIDOWED \_\_\_\_\_

LIVING ARRANGEMENTS: LIVE ALONE \_\_\_\_\_ SPOUSE/CHILDREN \_\_\_\_\_ RELATIVE \_\_\_\_\_ OTHER: \_\_\_\_\_

PRIMARY CAREGIVER IN THE HOME: LIVE ALONE \_\_\_\_\_ SPOUSE/CHILDREN \_\_\_\_\_ RELATIVE \_\_\_\_\_ OTHER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_ EMPLOYER'S PHONE: \_\_\_\_\_

MAJOR LIFE STRESSES: SCHOOL \_\_\_\_\_ WORK \_\_\_\_\_ DIVORCE \_\_\_\_\_ OTHER: \_\_\_\_\_

EDUCATION (Highest Grade Completed): \_\_\_\_\_ RELIGIOUS PREFERENCE: \_\_\_\_\_

PETS: \_\_\_\_\_ HOBBIES: \_\_\_\_\_

DESCRIBE REGULAR EXERCISE: \_\_\_\_\_