PATIENT MEDICAL HISTORY

Last Name_____ First Name_____ Maiden Name_____ A/C#_____

Address_____ City/State/Zip_____

Today s Date_____ Primary Care MD_____ Date of Birth ____/____/____ Age_____

Phone Numbers: Work_____ Home_____ Cell_____ E-Mail_____

Menstrual HX: Age at 1st Period_____ Age at Menopause_____ Birth Control Method_____ Hysterectomy: ☐ Yes ☐ No

OBSTETRICAL HISTORY:

TOTAL NUMBER OF PREGNANCIES:	NUMBER OF LIVING CHILDREN:_____ CHILDREN S AGES:
NUMBER OF STILLBIRTHS:	NUMBER OF MISCARRIAGES:
NUMBER OF ABORTIONS:	NUMBER OF CESAREANS:
OTHER OB HISTORY:	

ALLERGIES: MEDS/LATEX/FOODS ☐ NO ☐ YES *(PLEASE LIST):*

DRUG	REACTION

MAJOR MEDICAL CONDITIONS: DATE DIAGNOSED

HISTORY OF FAMILY ILLNESSES: WHICH RELATIVE:

BREAST CANCER	☐ YES	☐ NO
UTERINE CANCER	☐ YES	☐ NO
CERVICAL CANCER	☐ YES	☐ NO
OVARIAN CANCER	☐ YES	☐ NO
COLON CANCER	☐ YES	☐ NO
ALZHEIMER S	☐ YES	☐ NO
OSTEOPOROSIS	☐ YES	☐ NO
HIGH BLOOD PRESSURE	☐ YES	☐ NO
DIABETES	☐ YES	☐ NO
HEART DISEASE	☐ YES	☐ NO
HIGH CHOLESTEROL	☐ YES	☐ NO

OTHER SIGNIFICANT FAMILY HISTORY:

MEDICAL HISTORY:

DATE OF LAST PAP SMEAR:

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? ☐ YES ☐ NO

IF YES, TREATMENT: ☐ CRYO ☐ LASER ☐ LEEP

OPERATIONS/HOSPITALIZATIONS: *(PLEASE LIST):*

DATE:

DATE:

DATE:

DATE:

DATE:

DATE:

DATE:

DATE:

MEDICATIONS (INCLUDING NON-PRESCRIPTION):

NAME OF DRUG	REASON FOR TAKING

SOCIAL HISTORY: HOW MUCH:

DO YOU SMOKE?	☐ YES	☐ NO
DO YOU DRINK ALCOHOL?	☐ YES	☐ NO
DO YOU USE CAFFEINE?	☐ YES	☐ NO
ANY RECREATIONAL DRUGS?	☐ YES	☐ NO
DO YOU EXERCISE?	☐ YES	☐ NO

TYPE OF EXERCISE/FREQUENCY:

HAVE YOU EVER HAD SEX? ☐ YES ☐ NO

TOTAL NUMBER OF SEX PARTNERS IN YOUR LIFE?

CURRENTLY SEXUALLY ACTIVE? ☐ YES ☐ NO

SEXUAL ABUSE? ☐ YES ☐ NO

SEXUALLY TRANSMITTED DISEASES? ☐ YES ☐ NO

LAST COLONOSCOPY/DATE: NORMAL ☐ ABNORMAL ☐

LAST BONE DENSITY/DATE: NORMAL ☐ ABNORMAL ☐

LAST MAMMO/DATE: NORMAL ☐ ABNORMAL ☐

LAST TETANUS SHOT/DATE:

IMMUNIZATIONS ☐ YES ☐ NO REFER TO PCP ☐

Patient s Name_____ A/C #_____

Do you currently have any of the following problems:

CONSTITUTIONAL SYMPTOMS:		***URINARY:***	
FEVER	☐ YES ☐ NO	RECURRENT BLADDER INFECTIONS	☐ YES ☐ NO
WEIGHT LOSS	☐ YES ☐ NO	URINARY FREQUENCY	☐ YES ☐ NO
WEIGHT GAIN	☐ YES ☐ NO	URINARY URGENCY	☐ YES ☐ NO
EYES:		URINARY INCONTINENCE (LEAKING)	☐ YES ☐ NO
BLURRED VISION	☐ YES ☐ NO	***MUSCULOSKELETAL:***	
GLAUCOMA	☐ YES ☐ NO	JOINT PAIN	☐ YES ☐ NO
EAR/NOSE/THROAT/MOUTH:		BACK PAIN	☐ YES ☐ NO
SINUS PROBLEMS	☐ YES ☐ NO	***SKIN:***	
RESPIRATORY:		SKIN RASH	☐ YES ☐ NO
FREQUENT COUGH	☐ YES ☐ NO	PERSISTENT ITCH/HIVES	☐ YES ☐ NO
SHORTNESS OF BREATH	☐ YES ☐ NO	***NEUROLOGICAL:***	
CARDIOVASCULAR:		DIZZY SPELLS	☐ YES ☐ NO
CHEST PAIN	☐ YES ☐ NO	HEADACHES	☐ YES ☐ NO
PHLEBITIS	☐ YES ☐ NO	INSOMNIA	☐ YES ☐ NO
HIGH BLOOD PRESSURE	☐ YES ☐ NO	MEMORY LOSS	☐ YES ☐ NO
BREASTS:		***ALLERGIC/IMMUNOLOGIC:***	
PAIN IN BREASTS	☐ YES ☐ NO	HAY FEVER	☐ YES ☐ NO
NIPPLE DISCHARGE	☐ YES ☐ NO	ARTHRITIS	☐ YES ☐ NO
BREAST LUMP(S)	☐ YES ☐ NO	***ENDOCRINE:***	
GASTROINTESTINAL:		EXCESSIVE THIRST	☐ YES ☐ NO
ABDOMINAL PAIN	☐ YES ☐ NO	TOO HOT/COLD	☐ YES ☐ NO
NAUSEA/VOMITING	☐ YES ☐ NO	FATIGUE	☐ YES ☐ NO
INDIGESTION/HEARTBURN	☐ YES ☐ NO	***HEMATOLOGIC/LYMPHATIC:***	
CONSTIPATION OR DIARRHEA	☐ YES ☐ NO	BRUISING	☐ YES ☐ NO
FECAL INCONTINENCE	☐ YES ☐ NO	HISTORY BLOOD CLOTTING/DVT	☐ YES ☐ NO
GYNECOLOGICAL:			
ABNORMAL BLEEDING	☐ YES ☐ NO	DO YOU FEEL SATISFIED WITH YOUR LIFE?	☐ YES ☐ NO
PAINFUL PERIODS	☐ YES ☐ NO	DO YOU FEEL SEVERELY DEPRESSED?	☐ YES ☐ NO
PAINFUL INTERCOURSE	☐ YES ☐ NO	HAVE YOU CONSIDERED SUICIDE?	☐ YES ☐ NO
ABNORMAL VAGINAL DISCHARGE	☐ YES ☐ NO	HISTORY OF EATING DISORDER?	☐ YES ☐ NO
PMS	☐ YES ☐ NO	DO YOU HAVE AN *ADVANCED DIRECTIVE?*	☐ YES ☐ NO
INFERTILITY	☐ YES ☐ NO	**NOTES:**	
FREQUENT VAGINAL INFECTIONS	☐ YES ☐ NO		

OFFICE USE ONLY

Reviewed by: _____ Signature _____ Date

_____ Signature _____ Date

_____ Signature _____ Date

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