Medical History

Patient Name ________________________ DOB _____________ Today's Date ___________

Reason for Visit: ____

List any medications you are currently taking - please include all over the counter medications and vitamins:

____

____

Allergies: ____

Date of last menstrual period: ______________________ Age of first menstrual period: ______

Age of menopause: ____________ Are you or have you ever been sexually active? Yes or No

OB History

How many?

Full term pregnancies ____

Premature pregnancies ____

Abortion induced ____

Miscarriage ____

Ectopic ____

Currently living ____

Multiple birth ____

Vaginal deliveries ____

C-sections ____

Chronic or current medical conditions (ex. Asthma, high blood pressure, diabetes)

____

____

Date of last pap: ________________ Date of last mammogram: __________________

Date of last dexa scan: ___________ Date of last colonoscopy: ___________________

Past GYN surgical history: *please circle all that apply and write year of occurrence**

D&C	Year _______	Hysterectomy	Year ______
Myomectomy	Year _______	Tubal ligation	Year _______
Laparotomy	Year _______	Endometrial ablation	Year _______
Laparoscopy	Year _______	C-section	Year _______
Breast Surgery	Type/Year _________	Gall Bladder removed	Year _______
Urethral sling	Year _______	Leep/Cone	Year _______

Past medical history: ____

____

History of sexual transmitted diseases: ____

Family History

Does anyone in your family have any of the following:

	Relationship	Maternal or Paternal
High Blood Pressure:	_____________________	_________________
Heart disease:	_____________________	_________________
Diabetes type I:	_____________________	_________________
Diabetes type II:	_____________________	_________________
Thyroid disease:	_____________________	_________________
Seizure disorder:	_____________________	_________________
Breast cancer:	_____________________	_________________
Ovarian cancer:	_____________________	_________________
Endometrial cancer:	_____________________	_________________
Colon cancer:	_____________________	_________________
Cervical cancer:	_____________________	_________________

Do you smoke? Yes __ No __ Former __ How many per day? ______ How many years? ____

Do you drink alcoholic beverages? Yes __ No __ How often? _________

Do you drink caffeine? Yes __ No __