

MEDICAL INFORMATION

Name: _____ Date of Birth: _____ Today's Date: _____

PERSONAL HISTORY

HAVE YOU HAD

YES NO UNSURE

- 1. Chicken pox
- 2. High blood pressure
- 3. Diabetes
- 4. Thyroid disease
- 5. Skin disease
- 6. Excessive Sweating
- 7. Anemia (other than in pregnancy)
- 8. Cancer
- 9. Sinus trouble
- 10. Asthma
- 11. Shortness of breath or chronic cough
- 12. Pneumonia
- 13. Chest pain
- 14. Tuberculosis
- 15. Rheumatic fever
- 16. Heart disease
- 17. Heart murmur
- 18. Jaundice (other than at birth)
- 19. Hepatitis
- 20. Gallbladder disease
- 21. Stomach trouble or ulcer
- 22. Rectal bleeding
- 23. Kidney infections
- 24. Recurrent bladder infections
- 25. Urine leakage
- 26. Urinary frequency
- 27. Epilepsy (convulsions)
- 28. Migraine headaches
- 29. History of depression / anxiety
- 30. Eating disorder
- 31. Physical assault
- 32. Sexual assault
- 33. Varicose veins
- 34. Breast disease
- 35. Thrombophlebitis (blood clot in vein)
- 36. Arthritis
- 37. Pelvic Inflammatory Disease (PID)
- 38. Genital warts
- 39. Chlamydia
- 40. Gonorrhea or syphilis
- 41. Herpes (genital or oral)

Weight
 Now _____ lbs
 1 yr ago _____ lbs
 Highest weight _____ year _____
 (excluding pregnancy)
 Height
 _____ ft _____ inches

GYNECOLOGIC HISTORY

Menses

Age at first period _____
 Date of first day of last period _____
 Regular periods? Yes No
 Menstrual cycle length _____ days
 (from month to month)
 Duration of flow _____ days
 Flow Light Medium Heavy
 Pain or cramps? Yes No
 Treatment of cramps _____
 Date of last Pap smear _____
 Previous abnormal Pap? Yes No
 Sexual partners: Male Female Both
 How many last year _____ in lifetime _____
 Are you actively trying to get pregnant? Yes No
 If not, what do you do to prevent an unplanned pregnancy? _____

 Previous method and dates used:
 Diaphragm _____
 Birth control pills _____
 Intrauterine device _____
 Other _____
 Do you do breast self exam? Yes No
 Date of last mammogram _____

PREGNANCY HISTORY

Please Indicate Accordingly (including terminations and miscarriages)

Termination (T) Miscarriage (M) Delivery (D)	Year	Baby's Weight	Sex	Type of Delivery	Complications

PAST HISTORY

Current medications _____

Current vitamins / herbal medicines _____

Allergies to medications _____ Type of reaction _____

Transfusions Yes No

Surgery: type, date & place _____

Hospitalizations: reason, date & place _____

Immunizations Tetanus yes no date _____ Rubella (German measles) yes no date _____
 Hepatitis B yes no date _____ Varicella (chicken pox) yes no date _____
 Hepatitis A yes no date _____ Pneumococcus yes no date _____

FAMILY HISTORY

	Living		Deceased	
	Age	Health Problems	Age	Cause
Mother				
Father				
Brother/ Sister				
Husband				
Son/ Daughter				

HAS ANY RELATIVE HAD	YES	NO	WHO
1. Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Suicide	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Twins	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Bleeding Easily	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	_____

SOCIAL HISTORY

Alcohol: Type _____ Quantity _____
 Cigarettes _____ pack/day _____
 Caffeine _____ cups/day _____
 Recreational Drugs _____
 Regular Exercise Yes No Times Per Week _____
 Type _____
 Occupation _____
 Marital Status Single Married
 Divorced Widowed