El Camino Women's Medical Group
Obstetrics, Gynecology, Infertility & Minimally Invasive Surgery

Medical history

General information:

Name: DOB:
Age: Primary doctor:

Past medical history:

Please list all allergies and your reaction: ☐ None

_____ _____
_____ _____

Please list all medications, including: birth control, supplements, herbs, vitamins, and over the counter drugs: ☐ None

_____ _____
_____ _____

Please list any medical illnesses: ☐ None

_____ _____
_____ _____

Please list all major injuries, surgeries, and/or hospitalizations you have had: ☐ None

_____ _____
_____ _____
_____ _____

Date of last physical exam: _____
Date of last mammogram: _____
Date of last colonoscopy: _____

Family history:

Please list any medical problems affecting close relatives:

Father:
Mother:
Paternal grandfather:
Paternal grandmother:
Maternal grandfather:
Maternal grandmother:

Paternal uncle:
Paternal aunt:
Maternal uncle:
Maternal aunt:
Siblings:
Children:
Spouse:

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Social History:

Do you use tobacco products? No Used to, but quit Yes
If yes, how many per day? And for how many years?
Do you drink alcohol? If so, how often?
Do you use recreational or illegal drugs?
How many servings of dairy products to you eat in an average day?
How many times a week do you exercise? What activities?
Do you have pets?
With whom do you live?
Has anyone threatened or hurt you in the last year?
What is your occupation?

Past gynecological history:

At what age did you have your first menses?
How often is it and for how many days?
Date of last Pap smear:
Have you ever had an abnormal Pap smear?
How old were you the first time you engaged in sexual intercourse?
How many sexual partners have you had in your life?
_____Male _____Female
Are you currently sexually active?
If so, how long have you been with your current partner?
Have you ever had a sexually transmitted infection?
If so, what kind and when?
Do you have concerns about your sex life that you wish to discuss?
Do you experience urinary leakage?

Past obstetrical history:

Number of pregnancies: Number of term births:
Number of preterm births: Number of miscarriages:
Number of abortions: Number of living children:
For each pregnancy:

Date	Weight	Gender	Type of delivery	Epidural?	Complications?