PERSONAL MEDICAL HISTORY

This is a confidential record of your medical history. Information you provide here will not be given to any other person, unless you authorize us to do so.

(Please Print).

Name:_____

Address:_____

City:_____ State:_____

Zip:_____

Phone: (_____)_____ Age:_____

DOB:_____/_____/_____

List any allergies you have:_____

MENSTRUAL HISTORY

Age when periods began: _____ Periods come every _____ days Date last period began:_____

If it was not typical, describe:_____

Number of tampons/pads used on day of heaviest flow:_____

Do you have cramps with your period? **Yes / No** Have you ever missed your period? **Yes / No**

If there have been any changes in your period over the last year, describe:_____

_____

OBSTETRICAL HISTORY

If you have **never** been pregnant, go to section titled **Medical History**

Have you been pregnant in the last year? **Yes / No**
How many times have you been pregnant?_____ Your age at first pregnancy?_____

Number of: Full-term pregnancies:_____ Premature deliveries:_____
Cesarean sections:_____
Miscarriages or stillbirths:_____ Abortions:_____

How old are your children? Age_____ Age_____ Age_____ Age_____ Age_____
Age_____

If they have any birth injuries or genetic problems, describe:_____

During pregnancy, did you have any problems/complications, like (check, if appropriate):

_____ High blood pressure _____ Diabetes _____ DES use

Other: _____

After pregnancy, did you have any problems/complications, like (check, if appropriate):

_____ Infection _____ Excessive bleeding Other: _____

GYNECOLOGIC HISTORY

Is this your first pelvic exam? **Yes / No** Date of last pelvic exam: _____ Last Pap smear: _____

Have you ever had an abnormal Pap smear? **Yes / No**
If so, describe: _____

Check if you have ever had:

_____ Herpes _____ Gonorrhea _____ Syphilis _____

Chlamydia _____ Venereal warts Other: _____

Do you have abnormal discharge or itching of the vagina? **Yes / No**

If you douche, how often? _____

Do you have pain or bleeding with sexual activity? **Yes / No**

Did your mother take DES when she was pregnant with you? **Yes / No / Don't know**

Do you have any questions concerning sexuality? _____

CONTRACEPTIVE HISTORY

If you are currently using birth control, what method? _____

How long have you used this method? _____ Problems, if any: _____

Place a check next to any other methods you have used:

_____ Pills	_____ Foam/spermicide	_____ Sponge
_____ Withdrawal	_____ Diaphragm	_____ IUD
_____ Condom	_____ Self sterile	_____ Partner sterile
_____ Patch	_____ Rhythm/Natural family planning	_____ Ring

If you have had any problems with these methods, describe: _____

If you want a birth control method now, indicate which method: _____

Do you want to have children in the future? **Yes / No**

MEDICAL HISTORY

Describe any hospitalizations you have had: _____

Describe any surgery you have had: _____

List any current medical problems: _____

List all medications (prescription and nonprescription) you take regularly: _____

_____

Do you now have, or have you ever had any of the following?

High blood pressure	Yes / No	Frequent headaches	Yes / No
Cancer	Yes / No	Heart disease/rheumatic fever	Yes / No
Vision problems	Yes / No	Lung problems/tuberculosis	Yes / No
Hyperlipidemia	Yes / No	Epilepsy/convulsions	Yes / No
Asthma	Yes / No	Stroke	Yes / No
Liver disease/hepatitis	Yes / No	Breast lumps/discharge	Yes / No
Phlebitis/clots in vein	Yes / No	Mononucleosis	Yes / No
Kidney/bladder problems	Yes / No	Varicose veins	Yes / No
Diabetes	Yes / No	German measles/rubella vaccine	Yes / No
Blood problems/anemia/sickle cell disease	Yes / No	Gallbladder disease	Yes / No
Thyroid disease	Yes / No		

Check if you smoke: _____ Cigarettes _____Cigar _____ Pipe How many per day?_____

Do you feel you have:

A drug or alcohol problem? Yes / No Any eating disorders? Yes / No Depression/emotional problems? Yes / No

FAMILY HISTORY

Are you adopted? Yes / No

Indicate who of your blood relatives (parents, grandparents, brothers or sisters) have or had any of the following problems:

Heart attack/coronary artery disease_____ High blood pressure _____

Breast cancer_____ Birth defects/genetic problems_____

Diabetes_____ Cancer_____

Sickle cell/Tay Sachs/Thalassemia_____ Stroke_____

Other_____

If you have any questions or additional comments, use this space:

_____

_____

PLEASE READ AND SIGN: "I acknowledge that the above information is correct and complete."

_____

Patient's Signature **Today's Date**