PATIENT MEDICAL HISTORY

Last name	First	Middle

Race	D.O.B.	Age	Height	Martial Status
				☐ Single ☐ Married ☐ Divorced ☐ Separated

Type of Visit	Details
☐ Complication	
☐ Routine pap smear & pelvic exam	
☐ Family planning	
☐ Infertility	
☐ Pregnancy verification	

Menstrual period

Age at first period (yrs old):

O younger than 10 O 10-12 O 13-15 O 16-18 O older than 18 O not started

Cycle (days apart):

O less than 20 O 20-22 O 23-25 O 26-28 O 28-30 O more than 30

O None O Regular O Irregular

Flow (days of bleeding):

O 1-2 O 3-4 O 5-6 O 7 or more O none

O Light O Medium O Heavy

Spotting or bleeding between periods: O Yes O No

Current Problems

Breast tenderness, discharge or lumps O Yes O No

Abnormal pap smear O Yes O No

Vaginal discharge O Yes O No

Vaginal burning /itching O Yes O No

Vaginal infection O Yes O No

Pelvic pain O Yes O No

Painful periods O Yes O No

Painful intercourse O Yes O No

Pregnancy O Yes O No

Blood in urine O Yes O No

Pain while urinating O Yes O No

Leak urine while coughing or laughing O Yes O No

Obstetrical history

Age at first pregnancy (yrs old):

O younger than 16 O 16-18 O 19-21 O 22-24 O 25-27 O 28-30 O older than 30

O never pregnant

Live births: O None O 1 O 2 O 3 O 4 O more than 4

Still births: O None O 1 O 2 O 3 O 4 O more than 4

Miscarriages: O None O 1 O 2 O 3 O 4 O more than 4

Abortions: O None O 1 O 2 O 3 O 4 O more than 4

Tubal pregnancy: O None O 1 O 2 O 3 O 4 O more than 4

Total pregnancies: O None O 1 O 2 O 3 O 4 O 5

O 6 O 7 O 8 O more than 8

Please list the method of birth control you are presently using: O Pill O IUD O Depo O Tubal

O None O Other

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General medical history

Diabetes	O Yes	O No
Family history of diabetes	O Yes	O No
Cancer or tumor	O Yes	O No
Family history of cancer or tumor	O Yes	O No
Heart disease	O Yes	O No
Kidney disease	O Yes	O No
Bladder infections	O Yes	O No
Liver disease (jaundice, hepatitis, cirrhosis)	O Yes	O No
Gonorrhea	O Yes	O No
Syphilis	O Yes	O No
Chlamydia	O Yes	O No
Venereal warts	O Yes	O No
Tuberculosis	O Yes	O No
Convulsions	O Yes	O No
High blood pressure (hypertension)	O Yes	O No
Blood clot in veins (thrombophlebitis)	O Yes	O No
Blood clots elsewhere (embolism)	O Yes	O No
Severe and/or frequent headaches	O Yes	O No
Depression	O Yes	O No
Nervousness	O Yes	O No
Sickle cell disease	O Yes	O No
Family history of breast cancer	O Yes	O No
Pregnancy glaucoma	O Yes	O No

Hospitalization and surgery

☐ Hospitalization: ______________________________

____

Example: Delivery 2002, surgery 2004

☐ Surgery: ______________________________

____

Example: Appendectomy 2003

Additional information

1. Please list allergies or reactions to foods or medications: ______________________________

____

☐ None

2. Please list all medications or drugs being taken now that were prescribed by a doctor or dentist (include what you take for chronic conditions, birth control, etc): ______________________________

____

☐ None

3. Please list all medications or drugs that you sometimes take, that were bought without prescription (such as aspirin, sleep medication, allergy and cold medicine, vitamins, herbal remedies, etc.): ______________________________

____

☐ None

Smoking:	O Never	O Less than 1 pack per day	O More than on pack per day	
Alcohol:	O Never	O Rarely	O Sometimes	O Often

Patient signature	Date	Reviewed by

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