Medical History

First Name_____ Last Name_____ Date_____

Birth Date_____ Age_____ Phone_____

Occupation_____ Last Menstrual Period_____

Emergency Contact Name_____ Phone_____ Relationship _____

Pregnancy History- Please list the number of each type of pregnancy. If none, indicate 0.

Live Births_____ Abortions____ Miscarriages____ Stillbirths____ Ectopic _____ Molar_____

Total Pregnancies (include current pregnancy) _____

Problems with pregnancies? ☐ No ☐ Yes (describe):_____

Do you think you are pregnant right now? ☐ Yes ☐ No ☐ Unsure If yes, what makes you think you are pregnant?_____

YES	NO		YES	NO		YES	NO	
☐	☐	Allergies (medication/food) _____ _____ _____	☐	☐	Diabetes	☐	☐	Sexually Transmitted Infections _____ _____
☐	☐	Anemia	☐	☐	Fibroids	☐	☐	Stomach/Bowel Problems
☐	☐	Anesthesia Problems	☐	☐	Headaches/Dizziness/Migraine	☐	☐	Stroke, DVT, Pulmonary Embolism or Blood Clot
☐	☐	Asthma/ Lung Disease	☐	☐	Heart Disease/Heart Attack	☐	☐	Surgeries _____ _____ _____
☐	☐	Bleeding Disorders	☐	☐	High Blood Pressure	☐	☐	Thyroid Problems
☐	☐	Body/Facial Piercings	☐	☐	High Cholesterol	☐	☐	Ovarian Cyst/Tumor
☐	☐	Breast Feeding (currently)	☐	☐	HIV/AIDS	☐	☐	Vision/Eye Problems
☐	☐	Breast Lumps	☐	☐	Kidney/Bladder Problems	☐	☐	Other Medical Conditions/Problems _____ _____ _____
☐	☐	C-Sections (*List Years/Reasons*) _____ _____	☐	☐	Liver Disease/Hepatitis			
☐	☐	Cancer	☐	☐	Malignant Hyperthermia			
☐	☐	Depression, Anxiety, Mental Health or Psychiatric Issues	☐	☐	Pap Smear_____(*Year*) Results Abnormal/HPV? _____			
			☐	☐	Pelvic Infection/PID			
			☐	☐	Seizures/Neurological Problems			
			☐	☐	Serious Injuries _____ _____			

Notes:

Do you have pain or bleeding with sex? ☐ Yes ☐ No

List all current medications, herbs, diet pills, minerals or vitamins: _____ _____

Sexual Partners: ☐ Men ☐ Women ☐ Both

Alcohol Use: ☐ Never ☐ Yes, *Drinks per day:* _____Last Use_____

Tobacco Use: ☐ Never ☐ Yes, Packs per day: _____ Last Use _____

Recreational Drug Use (except marijuana): ☐ Never ☐ Yes , Types_____Last Use_____

Do you experience sexual, physical, emotional or verbal violence/abuse? ☐ Yes ☐ No

Do you want referrals/help for violence/abuse ☐ Yes ☐ No

Family Medical History- For Parents and Siblings Only

☐ Diabetes

☐ Bleeding or Clotting Disorder

☐ Breast, Cervical, Ovarian or Uterine Cancer

☐ Hypertension, Stroke, Heart Disease

Menstrual History

What age was your first period?_____

Do you bleed monthly? ☐ Yes ☐ No

How many days?_____

Flow is: ☐ Heavy ☐ Moderate ☐ Light

Contraceptive History

What method(s) have you tried? ☑ all that apply

☐ Pills ☐ Patch ☐ Ring ☐ Shot/Depo ☐ IUD ☐ Implant

☐ Cervical Cap ☐ Diaphragm ☐ Condom ☐ Spermicide ☐ Fertility Awareness ☐ Withdrawal

☐ Other: _____

Current Method _____

Problems with your birth control? _____

Preferred method? _____

The privacy standards established by 2003 HIPPA Provisions address the privacy and security of patient data.
I have provided complete and accurate information about my Medical History.
I authorize Falls Church Healthcare Center to use my information for purposes of treatment, payment and health care only.

Patient Signature _____ **Date**_____

History Review by Med. Professional_____ Date_____ History Review by MD _____ Date_____