Medical History Form

TODAY'S DATE: ___________

Name: ____ Age: _______

Why are you here today? ____

____

____

____

OBSTETRIC HISTORY

	Number		Number		Number
Pregnancies		Abortions		Miscarriages	
Premature births (<37 weeks)		Live Births		Living Children	

No.	Birth Date	Weight at Birth	Sex	Weeks Pregnant	Type of Delivery	Physician's Notes
1.						
2.						
3.						
4.						

Any Pregnancy Complications?

☐Diabetes ☐Hypertension/High Blood Pressure ☐Preeclampsia/Toxemia ☐Other

History of Depression Before or After Pregnancy? ☐Yes ☐No

GYNECOLOGIC HISTORY

Date of last pap smear: _______________ Was it normal? ☐Yes ☐No

First day of last menstrual period: ______________ Was your last period normal: ☐Yes ☐No

Age at 1st period: ____________ Length of Flow: __________ Time Between Flow: ____________

Are your periods: ☐Light ☐Moderate ☐Heavy Age of 1st sexual intercourse: _______

# of Sexual Partners in last 30 days: _______ # of Partners (Lifetime): ________

Partners Are: ☐Men ☐Women ☐Both

Current Method of Contraception: Satisfied with Method ☐Yes ☐No

Past Contraceptive History:

Yes	No		Yes	No	
☐	☐	Do you plan to have more children in the future?	☐	☐	Have you ever had an abnormal pap smear?
☐	☐	Are you planning a pregnancy within the next year?	☐	☐	Have you had problems with your uterus, tubes, or ovarios?
☐	☐	Have you ever been forced to have sex?	☐	☐	Have you had any sexually transmitted infections? If yes: _________________ ________________________________
☐	☐	Do you have pain or bleeding with intercourse?			

Current Medications (Including hormones, vitamins, herbs, nonprescription medications)

Drug Name	Dosage	Who Prescribed	Drug Name	Dosage	Who Prescribed

Past Medical History - please include dates

Current medical problems:
Past medical problems:
Past hospitalizations (reasons):
Previous surgeries: ____ ____

Past Medical History

Illness	Yes	Physician's Notes
Headaches or migraines or dizziness	☐	
Seizures, epilepsy, convulsions, fainting	☐	
Thyroid disease	☐	
Chest pain with exercise or exertion	☐	
Asthma or breathing problems	☐	
Heart disease, murmurs, rheumatic fever	☐	
Heart attacks	☐	
Strokes, blood clots, pulmonary embolus	☐	
High cholesterol	☐	
Anemia, clotting problems, sickle cell	☐	
Elevated blood pressure	☐	
Elevated blood sugar	☐	
Rectal bleeding, pain, itching, or discharge	☐	
Kidney, bladder, urinary tract infections	☐	
Liver disease, hepatitis, jaundice	☐	
Psychiatric or emotional problems	☐	
Other:	☐	

Family History ☐ I am adopted and/or do not know my family history

Illness	Yes	Whom	Illness	Yes	Whom
Colon cancer	☐		Other heart disease	☐	
Breast cancer	☐		High blood pressure	☐	
Ovarian cancer	☐		Blood clots	☐	
Prostate cancer	☐		High cholesterol	☐	
_____________ cancer	☐		Stroke	☐	
Diabetes	☐		Other: ______________	☐	
Heart Attack before 50	☐		Other: ______________	☐	

Social History

Use of alcohol:	☐Never	☐Rarely	☐Moderate	☐Daily	If daily, how many per day: ____
Use of tobacco:	☐Never	☐Previously, but quit	☐Current, packs per day: ________		
Use of drugs:	☐Never	☐Type and Frequency: ____			

I, the patient, certify to the best of my knowledge that the above information is correct and complete.
____

Physician's Signature:
____