

PATIENT MEDICAL HISTORY

Name _____

Date _____

Age _____

First Day Of Last Menstrual Period _____

Reason for Today's Visit:

Social history (check)

Are you: Single _____ Married _____ Divorced _____ Widowed _____ Remarried _____

Have you completed: Grade School _____ High School _____ Junior College _____ College _____ Graduate School _____
Occupation: _____

Gynecological History

Age At Time of First Menses _____ Frequency of Menstrual Periods _____
Number Of Days Of Bleeding: Total _____ Heavy _____ Light _____
Bleeding Between Periods? _____ Pain With Periods? _____ Pain With Intercourse? _____
Other Pelvic Pain? _____ Are You Sexually Active? _____ Method Of Birth Control _____
Previous IUD Use? _____ Any Abnormal Pap Smears? _____

Any History Of : (check)

Gonorrhea _____ Herpes _____ Syphilis _____ Chlamydia _____ Venereal Warts _____ HIV _____ Hepatitis _____
Pelvic Inflammatory Disease _____ Fibroid Tumors Of The Uterus _____ Infertility? Yes No
Treatment? _____
Endometriosis? _____

Do You Have (Indicate **F = Frequently** **R= Rarely** or **N= No**)

Night sweats _____ Hot Flashes _____ Vaginal Dryness _____ Difficulty Sleeping _____
Memory Loss _____ Depression _____ Loss of Interest in Sex _____ Anxiety _____
Loss of Urine When you Cough or Sneeze _____

Pregnancies _____ Miscarriages _____ Abortions _____ Ectopic _____

Year	Weeks	Delivery Type	Weight	Anesthesia	Complications

Were Your Pregnancies Complicated By Hemorrhage? _____ Infection? _____
Infection With Group B Strep? _____ Diabetes? _____
Other Complications Of Pregnancy? _____

Any Personal History Of: (Check)

Urinary Tract Infections _____ Stomach Ulcers _____ High Blood Pressure _____ Thyroid Disease _____ Lupus _____
High Cholesterol _____ Eating Disorders _____ Physical/Sexual Abuse _____ Liver Disease _____ Stroke _____
Heart Disease _____ Broken Bones _____ Mental Illness _____ Osteoporosis _____ Asthma _____
Depression _____ Migraines _____ Diabetes _____ Seizures _____ Hepatitis _____ Blood Clots _____

Any history of cancer? Yes No What Type? _____ What treatment did you have? _____
Other Illnesses? _____

