



Medical Record Number:

Patient name

Label

The information on this sheet is confidential

Name:	Date of Birth:	Referred by:
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MENSTRUAL History:

Age Started	Flow Type	Cycle length	Any of the following:
	<input type="checkbox"/> Light <input type="checkbox"/> Average <input type="checkbox"/> Heavy	(Days between 1st day of periods)	<input type="checkbox"/> PMS <input type="checkbox"/> Menstrual cramps
			<input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Pain with intercourse

GYNECOLOGICAL History

Age of first sexual encounter:	Total # of partners: _____	Currently sexual active? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last pap smear:
Received HPV Vaccine: <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth Control: <input type="checkbox"/> None/trying to conceive	<input type="checkbox"/> Patch	<input type="checkbox"/> Nexplanon date placed: _____
History STDs <input type="checkbox"/> Herpes <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> HPV <input type="checkbox"/> HIV	<input type="checkbox"/> Condoms <input type="checkbox"/> Pill <input type="checkbox"/> Nuva Ring	<input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Natural Family Planning	<input type="checkbox"/> IUD date placed: _____ <input type="checkbox"/> Skyla <input type="checkbox"/> Kyleena <input type="checkbox"/> Mirena <input type="checkbox"/> Paragard

What form of birth control have you used in the past? When?
If postmenopausal

When was your last period: _____ Hormone therapy? Yes No If yes, currently using:

What form of hormone therapy have you used in the past? When?

Any of the following: please mark w 'X' and write details in the space provided

<input type="checkbox"/> Abnormal pap	<input type="checkbox"/> Ectopic pregnancy	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Genital warts
<input type="checkbox"/> Infertility	<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Ovarian cysts	<input type="checkbox"/> Recurrent miscarriage
<input type="checkbox"/> Fibroids	<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Vaginal infections	<input type="checkbox"/> Vulvar pain

Details:

OBSTETRIC History

Number of pregnancies:	Vaginal deliveries:	Cesarean sections:	Miscarriages:
Elective terminations:	Premature births:	Stillborns:	

Pregnancies

#	Date	Wks at delivery	Delivery type	Baby weight	Sex	Complications
1						
2						
3						
4						
5						

SOCIAL History:

Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic partnership	Habits: Smoker: <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> Never if current smoker, how many/day? _____ if previous smoker, when did you quit? _____
Patient ethnicity: _____ Partner's ethnicity: _____ Patient Occupation: _____ Patient Employer: _____	Recreational drugs: _____ Alcohol: #drinks _____ per <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month Exercise? Times/week? _____

Last Mammogram:	Last Colonoscopy:	Last Bone density test:	Last Tetanus Shot:	Last Flu Shot:
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Other Physicians:

Please complete reverse side.

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MEDICAL History: please mark any positives and write details in the space provided

Allergies	Depression	Hemorrhage	Kidney stones
Anemia	Postpartum depression	Blood transfusion	Liver disease
Anxiety	Diabetes (type 1 or 2)	High cholesterol	Hepatitis
Asthma/lung disease	Eating disorder	Hypertension	Osteoporosis
Cough	Epilepsy	Irritable bowel syndrome	Positive TB screening
ADHD	Gastritis/ulcer	Change in bowels	Tuberculosis
Cancer	GERD (reflux)	Blood in stool	Stroke
Breast problem	Gestational diabetes	Hyperthyroidism	Bladder infections
Cholecystitis (gall bladder)	Heart disease	Hypothyroidism	Kidney disease
Blood coagulation defect/hemophilia	Headaches (tension/migraine)	Urinary incontinence/poor bladder control	Other:

Details:

SURGICAL History: Please record any surgical procedures and the approximate dates

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MEDICATIONS: Please list all current prescription medications and doses; also list over the counter medications and supplements

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ALLERGIES TO MEDICATIONS: NONE / or list and what reaction you had?

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FAMILY History: If yes please mark with 'X'

Cancer	List relative, maternal or paternal	Age of diagnosis if known
Breast		
Uterine		
Ovarian		
Cervical		
Colon		
Other Gastrointestinal		
Other		

Disease	List relative, maternal or paternal	Age of diagnosis if known
Diabetes		
Hypertension		
Heart disease		
Stroke		
Genetic disorder		

Signature: _____

Date: _____

I have read my MEDICAL HISTORY above and confirm that it adequately states past and present condition.