Medical History

Name____ **Age**_____ **Today's Date:** ____________________

Address_________________________________**Apt.**______**City**_______________**State**_____**Zip**___________

Home Phone ( ) _______________ **Work Phone** ( ) _______________**ext.**______ **Cell** ( ) _________________

Please leave a phone # where we can leave personal messages ( ) ____

Date of Birth _____/_____/_____ **SSN** ____ _____ _______ **Referred by** __________________________________

Marital Status: M S D W Occupation ____________________**Email Address:** _____________________________

Please provide Pharmacy # ____

GYNOCOLOGIC HISTORY:

Last Menstrual Period _____/_____/_____
Previous Menstrual Period ____/____/____
Menstrual interval _______ days
Duration of flow ________ days
Age of first menstruation _______
Cramps with Period **(Yes) (No)**
Present Contraception ______________
Past Contraception _________________
Last Pap Smear ____
Past Abnormal Pap Smear? **(Yes) (No)**
Last Mammogram____
Are you sexually active? ____
Sexual preference ____
Do you have sexual difficulties? ____
Have you ever been sexually abused? ____

PAST INFECTIONS:

(please check all which apply)
( ) Herpes
( ) Gonorrhea
( ) Genital Warts/HPV
( ) Trichomonas
( ) Syphilis
( ) Chlamydia
( ) Other ________________

PREGNANCY HISTORY:

Total pregnancies ____________ Live term births _____________ Abortions ______________________________
Premature births_____________ Miscarriages ________________ Stillbirths ______________________________
Ectopic pregnancies __________ Previous C- section ____

ALLERGIES: ____
MEDICATIONS/VITAMINS/HERBAL SUPPLEMENTS: ____

MEDICAL HISTORY:

( ) Heart Disease
( ) Diabetes
( ) Kidney Disease
( ) Anemia
( ) Hypertension
( ) Genetic Disease
( ) Seizure Disorder
( ) Lung Disease
( ) Mental Illness
( ) Smoking
( ) Drug Use
( ) Alcohol use ( ) occasional ( ) regular
( ) No problems

FAMILY HISTORY:

( ) Heart Disease
( ) Diabetes
( ) Kidney Disease
( ) Anemia
( ) High Blood Pressure
( ) Genetic Disease
( ) Seizure Disorder
( ) Cancer
( ) Mental Retardation
( ) Mental Illness
( ) Multiple Pregnancy
( ) Infertility
( ) Other

FAMILY HISTORY:

( ) Blood Clots/Stroke

Please list all surgeries: ____
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