

**Patient Medical History Form**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Marital Status: S  M  D  W  Occupation: \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

**Medical History:**

Have you ever been treated for any medical problems? Yes  No

Please circle any that apply:

- |              |                     |                            |
|--------------|---------------------|----------------------------|
| Anemia       | Ulcer               | Heart Disease              |
| Migraines    | High Blood Pressure | Thyroid disease            |
| Stroke       | Bladder Infections  | Rheumatic Fever            |
| Diabetes     | Blood clots         | Psychiatric Problems       |
| Heart Murmur | Kidney Stones       | Liver Problems             |
| Cancer       | Seizures            | Breast Problems / Biopsies |
| Asthma       | High Cholesterol    | Stomach/Bowel Problems     |
| HIV          | Other: _____        |                            |

Have you ever been hospitalized? Yes  No

If yes, please list dates and reasons:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had any surgeries? Yes  No

If yes, please list dates and procedures:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had a blood transfusion? Yes  No

If yes, what was the reason? \_\_\_\_\_

Do you take antibiotics prior to procedures such as dental visits? Yes  No

**Allergies to Medications:**

Name of medicine and reaction: \_\_\_\_\_

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Name of medicine and reaction: \_\_\_\_\_

Are you allergic to Latex? Yes  No  Reaction: \_\_\_\_\_

**Current Medications including over the counter medications:**

Name: \_\_\_\_\_ Dose: \_\_\_\_\_ How often: \_\_\_\_\_

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**Gynecologic History:**

Month/Yr : Last pap smear: \_\_\_\_\_ Last mammogram: \_\_\_\_\_ Last bone density: \_\_\_\_\_

Age at first period: \_\_\_\_\_ Age at menopause: \_\_\_\_\_

Have you ever had an abnormal pap smear? Yes  No

If yes, when, and what treatment did you have? \_\_\_\_\_

Have you ever been told that you have any of the following? Please circle:

Endometriosis                      Ovarian cysts                      Fibroids

**Menstrual History:**

Number of days between periods (1<sup>st</sup> day to 1<sup>st</sup> day of next period): \_\_\_\_\_

Number of days of bleeding: \_\_\_\_\_ Light  Moderate  Heavy  Pain

Do you have any bleeding between your periods? Yes  No

Are you currently sexually active? Yes  No

Do you have any vaginal bleeding after intercourse? Yes  No

Do you have pain with intercourse? Yes  No

Age at first intercourse: \_\_\_\_\_

What forms of birth control have you used in the past? Please circle:

Oral contraceptives (pills)                      Rhythm                      Depo-provera  
Condoms                      Diaphragm                      Norplant  
Ortho-evra (patch)                      Cervical cap                      IUD  
Spermicides                      Tubal ligation                      Withdrawal  
Partner has vasectomy                      Nuvaring

What form of birth control are you using now? \_\_\_\_\_

Have you ever had any sexually transmitted infection? Yes  No  Please circle:

Gonorrhea                      Chlamydia                      Syphilis                      Genital warts  
Trichomonas                      Genital herpes                      HPV                      PID

Sexual preference: Men  Women  Both

**Pregnancy History:**

# of pregnancies: \_\_\_\_\_ Living children: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

Abortions: \_\_\_\_\_ Ectopics (tubal): \_\_\_\_\_

**Social History:**

Do you smoke? Yes  No

Do you drink alcohol? Yes  No  If yes, how many drinks per week? \_\_\_\_\_

Do you use any recreational drugs? Yes  No  If yes, which ones? \_\_\_\_\_

Do you have a history of domestic violence or sexual abuse? Yes  No

Do you exercise regularly? Yes  No

**Family History:**

Has anyone in your family had any of the following: (if yes, please note relationship)

Breast Cancer: Yes  No  \_\_\_\_\_

Uterine Cancer: Yes  No  \_\_\_\_\_

Ovarian Cancer: Yes  No  \_\_\_\_\_

Colon Cancer: Yes  No  \_\_\_\_\_

Stroke: Yes  No  \_\_\_\_\_

Diabetes: Yes  No  \_\_\_\_\_

Blood Clotting problems: Yes  No  \_\_\_\_\_

High blood pressure: Yes  No  \_\_\_\_\_

Heart Attack: Yes  No  \_\_\_\_\_

Thyroid Disease: Yes  No  \_\_\_\_\_

Is there anything else that you feel we should know? \_\_\_\_\_