PATIENT MEDICAL INFORMATION

Name: _____ DOB:_____ Age:_____
Reason for your visit: _____

Pregnancy History:

Number of times ever pregnant	Number of live births	Number of miscarriages	Number of abortions

Menstrual History:

Age when you got your first period? (Menarche): _____Date of the first day of your last period (L.M.P.): _____
Number of days between periods: _____ How many days do your periods last? _____
Flow is : [ ] Normal [ ] Heavy [ ] Light Number of pads in a 24 hour period of heaviest flow:_____
Pain with periods? _____ If yes, is your pain [ ] mild [ ] moderate [ ] severe. Any premenstrual symptoms (bloating, mood swings, etc)? _____ If yes, please describe: _____

Pap smear history:

Last Pap smear date: _____ Place: _____ Result: _____
Have you ever had treatments for abnormal Pap smear? _____ If yes, describe: _____

Contraceptive history:

Have you ever used contraceptives? _____ If yes, please circle all that you have used to prevent pregnancy:

1. Birth Control pills	2. I.U.D.	3. Condoms	4. Norplant
5. Depo Provera Injection	6. Diaphragms	7. Spermicidal	8. Tubal Ligation
9. Natural family Planning	10.Cervical Cap	11.Withdrawal	12.Vasectomy

What method(s) are you currently using? _____ for how long? _____
Are you attempting pregnancy at this time?_____ for how long?_____
What contraceptive method do you want to use now, if any? _____

Social Habits:

Do you smoke tobacco? _____ If yes, # of packs per day_____ for how many years? _____
Do you drink alcohol? _____ If yes, # drinks _____ per week.
Do you use street drugs? _____ If yes, what type(s) and amount_____
Did you ever use street drugs? _____ If yes, what type(s) _____ when did you quit? _____

Review of current systems. Do you currently have the following complaints? Please mark all that apply:

[ ] Burning, pain or frequent urination. How long?_____
[ ] Vaginal discharge. If yes, describe_____
[ ] Loss of urine with cough or sneeze. How long?_____
[ ] Chest pain. Have you seen a cardiologist?_____
[ ] Difficulty breathing_____
[ ] Spotting/ bleeding after intercourse? _____
[ ] Recent significant weight change. Indicate if you lost or gained and # of pounds_____
[ ] Frequent headaches? How long?_____
[ ] Dizzy spells? How long?_____
[ ] Stomach or intestinal pains? How long?_____
[ ] Fever now or recently?_____
[ ] Hay fever allergies, respiratory problems?_____
[ ] Work problems?_____
[ ] Family problems?_____
[ ] Depression?_____
[ ] Suicidal thoughts?_____

Current medications and dosages _____
_____

Name_____ **DOB:** _____

List all medications you have had allergic reactions to:_____
Explain what your reactions were:_____

Past Hospitalizations and operations, state dates and reason for admission:

_____

_____

Medical History. Please indicate type of problem and who suffers it.

X	Disease	**SELF**	Father	Mother	Sibling	Other / Comments
	High Blood Pressure					
	Heart Disease					
	Asthma					
	Emphysema / lung disorder					
	Diabetes					
	Liver disease					
	Kidney problems					
	Stomach / intestinal problems					
	Rheumatic fever					
	Epilepsy					
	Bleeding disorders					
	Anemia					
	Depression					
	Emotional problems					
	Breast disease / lump					
	Bone / Joint disease					
	Cancer (state type of Cancer)					
	Stroke					
	Phlebitis / Varicose veins					
	Clots in veins or lungs					
	Migraine headaches					
	Malaria / Tropical disease					
	Hepatitis					
	Rubella					
	Varicella (chicken pox)					
	EBV (Epstein Bar virus)					
	CMV					
	Sexually transmitted disease					
	Infection of uterus/tubes/ovaries					
	Thyroid problems					
	Congenital abnormalities					

The following questions are important to determine your risk for cancer and other diseases. Like all information it is kept confidential.
Total # of sexual partners _____ Age at first intercourse _____ Are you sexually active now?_____
[ ] Decreased sex drive [ ] Pain with intercourse [ ] Bleeding after/during intercourse [ ] History of sexual abuse

Pregnancy history. Please write the following information for each one of your pregnancies.

Month And Year	# of months	Baby's Sex	Baby's Weight	Problems during pregnancy	Hrs in labor	Place of birth	Problems during delivery	Vaginal or C/Sec

Patient's Signature: _____ Date: _____