Northfield Hospital + Clinics

Personal & Family Medical History

Patient Information Sticker

Date: _____

Allergies: _____

_____

Medications — *Please list all of the medications you are taking, including any vitamins, herbal medicines and "over-the-counter" medications.*

Name of Medication	Dose	Frequency

Medical History — *Please check* (❑) *if you have had any of the following conditions.* ❑ None

❑ Cancer (type: _____) ❑ Stroke ❑ Bowel or G.I. disorder ❑ Osteoporosis or Osteopenia

❑ Breast biopsy ❑ D.V.T. or P.E. ❑ G.E.R.D. ❑ Glaucoma or eye problems

❑ Heart attack ❑ Bleeding or clotting disorder ❑ Liver disease or hepatitis ❑ Migraines

❑ Heart surgery ❑ Anemia ❑ Kidney disease ❑ Seizure disorder

❑ Heart murmur ❑ Asthma ❑ Diabetes ❑ Depression or mental illness

❑ Hypertension ❑ Lung disease ❑ Thyroid disease

❑ Other: _____

Obstetric and Gynecologic History

Total # of pregnancies: _____ # of vaginal deliveries: _____ # of C-sections: _____

# of children: _____ # of miscarriages: _____ # of abortions: _____

# of adopted: _____

Are you in menopause? ❑ Yes ❑ No If no, please complete the following

Date of last menstrual period: _____ # of days between cycles *(first day of one to the first day of the next):* _____

Length of flow: _____

Date of last Pap Smear: _____ Have you had any abnormal Pap Smears? ❑ Yes ❑ No If yes, when? _____

Are you currently sexually active? ❑ Yes ❑ No Total number of partners in your lifetime: ❑ 0 ❑ 1-5 ❑ 6-10 ❑ >10

My partner(s) is(are): ❑ Male ❑ Female ❑ Both

Have you ever had a sexually transmitted infection or pelvic inflammatory disease? ❑ Yes ❑ No

If yes, which one(s): _____

List any gynecologic procedures or surgeries that you have had: _____

_____

Method of Birth Control

❑ Birth control - pill ❑ Condoms ❑ Implant / Implanon ❑ Sponge / spermicide

❑ Birth control - patch ❑ Diaphragm / cap / shield ❑ I.U.D. ❑ Tubal sterilization

❑ Birth control - ring ❑ Depo Provera ❑ Vasectomy ❑ Natural family planning

❑ None ❑ Other: _____

(continued, over...)

Immunizations: _____

_____

Please check (❑) *if you have any of the following:*

❑ Irregular or heavy periods ❑ Painful periods ❑ Leakage of urine
❑ Leakage of gas or stool ❑ Pain or bleeding with intercourse ❑ Breast lump, pain, or discharge
❑ Pain with urination ❑ Problems with sexual function ❑ Symptoms of depression

Surgical History

Please list all the surgeries you have had, including the dates: _____

_____

_____

Social History

Occupation: _____

Are you? ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated ❑ Significant other ❑ Other: _____

Highest level of education:

❑ College ❑ High School ❑ G.E.D. ❑ Other: _____

Do you smoke? ❑ Yes ❑ No If yes, how many cigarettes per day and for how long? _____

Do you drink? ❑ Yes ❑ No If yes, the number of drinks per day: _____

Have you ever used any recreational drug? ❑ Yes ❑ No If yes, which one(s) and when? _____

Do you get regular exercise ❑ Yes ❑ No If yes, how often? _____

Do you have any dietary restrictions? ❑ Yes ❑ No If yes, what restrictions? _____

Do you feel safe at home? ❑ Yes ❑ No

Do you want to discuss abuse? ❑ Yes ❑ No

Family Medical History

Condition	Father	Mother	Sibling	Maternal Grandfather/ Grandmother	Paternal Grandfather/ Grandmother	Child
Diabetes						
Stroke						
Heart disease						
High cholesterol						
High blood pressure						
Bleeding disorders						
D.V.T. / P.E.						
Breast cancer						
Ovarian cancer						
Uterine cancer						
Colon cancer						
Other cancer (specify type)						
Osteoporosis						
Depression / mental illness						
Drug / alcohol dependence						
Other health problems						