Personal & Family Medical History

Date: __________________________

Allergies: ______________________________________________________________________________________________
____________________________________________________________________________________________________

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

☐ Cancer (type: _______)
☐ Breast biopsy
☐ Heart attack
☐ Heart surgery
☐ Heart murmur
☐ Hypertension
☐ Other: __________________________________________________________________________________

☐ Stroke
☐ D.V.T. or P.E.
☐ Bleeding or clotting disorder
☐ Anemia
☐ Asthma
☐ Lung disease

☐ Bowel or G.I. disorder
☐ G.E.R.D.
☐ Liver disease or hepatitis
☐ Kidney disease
☐ Diabetes
☐ Depression or mental illness

☐ Osteoporosis or Osteopenia
☐ Migraines
☐ Seizure disorder
☐ Glaucoma or eye problems

Medical History — Please check (☐) if you have had any of the following conditions.

☐ None

Cancer (type: _______)
Breast biopsy
Heart attack
Heart surgery
Heart murmur
Hypertension

Stroke
D.V.T. or P.E.
Bleeding or clotting disorder
Anemia
Asthma

Bowel or G.I. disorder
G.E.R.D.
Liver disease or hepatitis
Kidney disease
Diabetes

Osteoporosis or Osteopenia
Glaucoma or eye problems
Migraines
Seizure disorder
Gastrointestinal disorder

Medical History — Please check (☐) if you have had any of the following conditions.

☐ None

Cancer (type: _______)
Breast biopsy
Heart attack
Heart surgery
Heart murmur
Hypertension

Stroke
D.V.T. or P.E.
Bleeding or clotting disorder
Anemia
Asthma

Bowel or G.I. disorder
G.E.R.D.
Liver disease or hepatitis
Kidney disease
Diabetes

Osteoporosis or Osteopenia
Glaucoma or eye problems
Migraines
Seizure disorder
Gastrointestinal disorder

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
☐ Birth control - patch
☐ Birth control - ring
☐ None

☐ Condoms
☐ Diaphragm / cap / shield
☐ Depo Provera
☐ Other: __________________________________________________________________________________

☐ Implant / Implanon
☐ I.U.D.
☐ Vasectomy

☐ Sponge / spermicide
☐ Tubal sterilization
☐ Natural family planning

(continued, over...)
Immunizations: _____________________________________________________________

___________________________________________________________________________________________

Please check (☑) if you have any of the following:
[ ] Irregular or heavy periods
[ ] Painful periods
[ ] Leakage of urine
[ ] Breast lump, pain, or discharge
[ ] Leakage of gas or stool
[ ] Pain or bleeding with intercourse
[ ] Symptoms of depression
[ ] Pain with urination
[ ] Problems with sexual function
[ ] Pain or bleeding with intercourse
[ ] Breast lump, pain, or discharge
[ ] Leakage of gas or stool
[ ] Pain or bleeding with intercourse
[ ] Symptoms of depression
[ ] Pain with urination
[ ] Problems with sexual function

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, which one(s) and when? ________________________________

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

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