aventa
specialized women's care

Medical History Form

137 Clinic Drive
Dothan, Alabama 36303

phone 334-699-2229
fax 334-699-4084

web aventawoman.com

Name _____ Age _____ Date of Visit _____ DOB _____

Marital Status _____ Primary Care Physician _____ Previous Gynecologist _____

Who referred you to our office? _____ Purpose of Today's Visit _____

Personal Medical History *(please check all that apply)*

CARDIOVASCULAR	✗
Cardiac catheterization	
DVT/blood clot	
Heart attack	
Heart murmur	
Heart problems	
High blood pressure	
High cholesterol	
Pulmonary embolus	
Stroke	
Other:	

DIGESTIVE	✗
Constipation	
Crohn's disease	
Diarrhea	
GERD (reflux)	
Hepatitis	
Irritable bowel syndrome	
Stomach ulcers	
Ulcerative colitis	
Other:	

GYNECOLOGIC	✗
Abnormal pap	
Bleeding after menopause	
Chlamydia	
Fibroids	
Gonorrhea	
Herpes	
HPV	
Ovarian cysts	
Pelvic inflammatory disease	
Trichomonas	
Other:	

HEMATOLOGIC	✗
Anemia	
B12 deficiency	
Blood transfusions	
Vitamin D deficiency	
Sickle cell disease/trait	
Other:	

ENDOCRINE	✗
Adrenal gland disorder	
Diabetes	
Pituitary disease	
Thyroid disease	
Other:	

KIDNEY	✗
Kidney infection	
Kidney stones	
Urinary tract infection	
Other:	

MUSCULOSKELETAL	✗
Arthritis	
Fracture	
Joint pain	
Osteopenia	
Osteoporosis	
Other:	

PSYCHOLOGIC/NEUROLOGIC	✗
ADHD	
Anxiety	
Bipolar disorder	
Depression	
Postpartum depression	
Migraines	
Chronic headaches	
Seizures	
Other:	

OTHER	✗
Glaucoma	

PULMONARY	✗
Asthma	
Chronic bronchitis	
COPD	
Pneumonia	
Tuberculosis	
Other:	

Anything else not listed above:

Surgeries and Hospitalizations

REASON	YEAR	REASON	YEAR

Sexual History *(circle what applies)*

Have you ever had sexual intercourse?	Yes No	Number of years since onset:
Are you sexually active now (within the last year)?	Yes No	Number of partners in the last year:
Have you ever been diagnosed with an STD?	Yes No	Type:
What are you currently using for birth control? *(Circle ALL that apply)*	Birth control pills | Condoms | Implanon | Vasectomy | Tubal | IUD | Depo-Provera | None | Other:	

Menstrual History

PREMENOPAUSAL WOMEN					MENOPAUSAL WOMEN		
Age cycle began:	Breakthrough bleeding?		Yes	No	Age of menopause:		
Date of last cycle:	Flow?	Light	Medium	Heavy	Bleeding since?	Yes	No
Length of cycle:	Clots?		Yes	No	Hot flashes?	Yes	No
Time between cycles:	Pain/cramps?		Yes	No	Vaginal dryness?	Yes	No

What medications do you use for menstrual cramps?

Social History

Smoking	Yes	No	Packs per day:	Number of years:	Former smoker?	Yes	No	
Alcohol	Yes	No	Drinks per day:	Drinks per week:	Number of years:			
Drug Use	Yes	No	Drugs used:					
Regular Exercise	Yes	No	How often:					
Occupation:								

OB History *(Include miscarriages & abortions. Method of delivery: C-section, forceps, vacuum, or vaginal)*

Date	Method of Delivery	Weeks	Male or Female?	Weight	Physician & Facility	Pregnancy Complications

Current Medications and Dosage *(include vitamins and herbal supplements)*

Medication and dosage	Medication and dosage	Medication and dosage

Are you allergic to Latex?

Yes No

Allergies: _____

_____

_____

Preventative Care History

Procedure *(most recent)*	Date	Normal?	History of abnormal? *(List treatments, i.e. LEEP, cryo, laser, cold knife cone AND year of treatment)*
Pap		Yes No	Yes No
Mammogram		Yes No	Yes No
Colonoscopy		Yes No	Yes No
Bone Density		Yes No	Yes No

Does anyone in your family have a history of:

Cancer	Relative(s)	Age at diagnosis
Breast cancer		
Uterine cancer		
Ovarian cancer		
Colon cancer		
Other cancer		

To be completed by health care provider: Height _____ Weight _____ BP _____