Name: Date of Birth:

Personal Medical History:

Please indicate whether you have or have had any of the following health problems:

Migraine headaches	☐ Yes	☐ No	Liver disease, ulcers, colitis	☐ Yes	☐ No
Seizures, stroke, neurological	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Eye disease	☐ Yes	☐ No	Bleeding disorder	☐ Yes	☐ No
Ear or hearing problems	☐ Yes	☐ No	Clotting disorder	☐ Yes	☐ No
Thyroid problems	☐ Yes	☐ No	Autoimmune disease (lupus, etc)	☐ Yes	☐ No
Lung disease, asthma, COPD	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Heart disease, MVP or murmur	☐ Yes	☐ No	Osteopenia or osteoporosis	☐ Yes	☐ No
Hypertension (high blood pressure)	☐ Yes	☐ No	Other serious medical problems	☐ Yes	☐ No
Kidney problems	☐ Yes	☐ No	**List:** _____		

Medications ☐ None

Please list all prescription medications you are currently taking:

Drug Name	Dose and schedule	Reason prescribed

Please list all non-prescription medications you are currently taking (vitamins, herbals, etc):

Allergies Please list all medication and food allergies: ☐ None known

Tobacco: ☐ Never ☐ Quit ☐ 1/2 ppd or less ☐ 1 ppd ☐ > 1 ppd **Drugs:** ☐ None ☐ Quit ☐ Social ☐ Frequent

Alcohol: ☐ Never ☐ Quit ☐ Social (once a week or less) ☐ 1 or less per day ☐ More than 1/day

Surgeries and Hospitalizations: ☐ None

Please list all overnight hospitalizations and all surgeries (include outpatient surgery), beginning with the most recent (do not include pregnancies - list them below in the OB section):

Date	Procedure or Hospital Reason	Date	Procedure or Hospital Reason

Last Mammogram date _____ **Results** _____ **Last Pap** **Results**

Last Bone Density date _____ **Results** _____ **Colonoscopy** _____ **Res** _____

Name: Date of Birth:

Gynecologic History: **Age 1st period:** **Age 1st intercourse:** **Total # partners** **Age at menopause:**

Cycles: ☐ Regular, 21-35 days ☐ Less than 21 days ☐ Longer than 35 days ☐ Irregular ☐ N/A

Duration: ☐ Irregular ☐ Length 3-8 days ☐ Less than 3 days ☐ Longer than 8 days ☐ N/A

Flow: ☐ light ☐ heavy ☐ normal ☐ N/A

Current Contraception ☐ Condoms ☐ Hormonal contraceptive ☐ IUD ☐ Tubal ☐ Menopause ☐ Desire to conceive ☐ Diaphragm ☐ Hysterectomy ☐ NFP ☐ Vasectomy ☐ None needed

Please indicate if you have ever had any of the following: ☐ Negative

☐ Abnormal pap smear	☐ Fibroids	☐ Herpes	☐ HPV vaccine
☐ Procedures of cervix (LEEP, colpo)	☐ Chronic vaginal infections	☐ HIV	
☐ Infertility	☐ Chlamydia	☐ Pelvic Inflammatory Disease (PID)	
☐ Ovarian tumors	☐ Gonorrhea	☐ Other STD	
☐ Endometriosis	☐ Condyloma or HPV	☐ DES exposure	

OB History: (Include miscarriages, ectopics, abortions) Total number of all pregnancies: _____

Date	Hospital	Weeks	Sex	Weight	Delivery type	Complications/ problems

Please indicate if you have recent problems in the following areas:

Breast ☐ Fibrocystic breasts ☐ Breast lump ☐ Breast pain ☐ Nipple discharge ☐ Abn. mammogram ☐ Neg

Gyn ☐ Abnormal bleeding ☐ Abnormal or irregular periods ☐ Severe midcycle pain ☐ Pelvic mass ☐ Abnormal discharge ☐ Severe menstrual cramps ☐ Pain with intercourse ☐ Neg

General ☐ Unexplained weight loss ☐ Malaise ☐ Fatigue ☐ Fever ☐ Night sweats ☐ Neg

Neuro ☐ Headache ☐ Vision problem ☐ Hearing loss ☐ Weakness ☐ Numbness ☐ Seizures ☐ Neg

Skin ☐ Pigmentation ☐ Change in mole ☐ Hair changes ☐ Neg

Cardio ☐ Chest pain ☐ Short of Breath ☐ Palpitations ☐ Irregular rhythm ☐ Neg

Resp ☐ Short of Breath ☐ Wheezing ☐ Cough blood ☐ Dry cough ☐ Productive cough ☐ Neg

Endocrine ☐ Heat intolerance ☐ Cold intolerance ☐ Hair changes ☐ Excess Hair ☐ Skin changes ☐ Neg

Intestinal ☐ Nausea ☐ Change in BM ☐ Tarry stools ☐ Constipation ☐ Vomit blood ☐ Vomiting ☐ Bleeding with BM ☐ Diarrhea ☐ Heartburn ☐ Trouble swallowing ☐ Neg

Urinary ☐ Pain with urination ☐ Blood in urine ☐ Leakage ☐ Trouble voiding ☐ Incontinence ☐ Dark urine ☐ Neg

Musc- Skel ☐ Joint pain ☐ Joint swelling ☐ Joint deformity ☐ Instability ☐ Weakness ☐ Muscle pain ☐ Neg

Family Medical History:

Not including yourself or relatives by marriage, please indicate if anyone in your family has had any of the following health problems:

☐ Unknown ☐ Entirely negative

Stroke, seizure	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child
Heart disease	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child
Hypertension	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child
Diabetes	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child
Kidney problems	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child
Bleeding disorder	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child
Clotting disorder	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child
Cancer, breast	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child
female organs	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child
colon	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child
other cancer	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child
Birth defects	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child
Twins or triplets	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child
Other diseases	☐ <none>	☐ M	☐ F	☐ S	☐ B	☐ MGF	☐ MGM	☐ MA	☐ MU	☐ PGF	☐ PGM	☐ PA	☐ PU	☐ Child

(M = mother, F= father, S= sister, B = brother, MGF = maternal grandfather, PGM =paternal grandmother, MA = maternal aunt, PU = paternal uncle, Child = your child)