

Patient History

Name: _____ DOB: _____ Date: _____

Past Medical History:

- | | | | | | |
|---|--|--|--|-------------------|--|
| Weight Loss | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Gain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood Clots | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lung Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Seizure Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anxiety/Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Genital Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| STDs (gonorrhea, chlamydia, syphilis, HPV, HIV) | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

Gynecological History:

Age at first period: _____ Age at last period: _____ First day of last period: _____
 Number of days between periods: _____ How many days do your periods last? _____
 Do you have blood clots with your periods? Yes No
 How would you rate your menstrual cramps? Mild Moderate Severe
 Date of Last Pap Smear _____ Normal Abnormal
 Date of Last Mammogram _____ Normal Abnormal

Obstetrical History:

Total number of pregnancies _____ Preterm deliveries (less than 37 weeks) _____ Miscarriages _____
 Abortions _____ Number of living children _____

Preg Year	Weeks Preg	M/F	Birth Weight	Type of Delivery	Complications	Hospital
1. _____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____	_____

Medications: (Please list all medications you regularly take, including nonprescription medications)

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

Drug Allergies:

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

Hospitalizations: (Please list all operations and serious illnesses. Do not list pregnancy admissions)

Year	Type of surgery or illness	Hospital
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Family History of Illness:

- Diabetes Blood Clots in lungs or legs High Cholesterol Breast Cancer
 Ovarian Cancer Uterine Cancer Other: _____

Social History:

Tobacco use: Cigarettes per day _____ # of years _____ Alcohol use: Rare Weekends Daily
 Street drug use: Yes No