

### 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