

MEDICAL HISTORY

Patient Name (Last Name, First Name) _____ Date of Birth: ____/____/____

The reason for my visit is: Annual Check-up & Pap Smear and/or _____

My last menstrual period began on _____ or I no longer have menstrual periods Hysterectomy in year _____ or Menopause in year _____

Current Method of Birth Control

- a. Birth Control Pills
- b. IUD
- c. Tubal Ligation
- d. Vasectomy by Partner
- e. Condoms
- f. None
- g. Not Sexually Active
- h. NuvaRing
- i. Essure

Pregnancy History: Times Pregnant _____ Living Children _____ Miscarriages _____ Abortions _____

	Born mo/yr	Weight at birth	Baby's Sex	Vaginal or C-Section	Full Term or Premature	COMPLICATIONS	Baby's Name
1.							
2.							
3.							
4.							

I have a period every _____ days lasting _____ days. I was _____ yrs old when I started having menstrual periods.

Have you had any changes or problems with your period? _____ Do you have problems with menstrual cramps? _____

Do you Smoke? _____ If yes, how much? _____ Drink Alcohol? _____ If yes, quantity? _____ Caffeine? _____ If yes, quantity? _____

Current medications _____

Drug allergies _____

Past surgeries or serious illnesses? _____

Last mammogram? _____ **Last pap smear?** _____ **Last colonoscopy?** _____

Do you have an Advanced Directive? (Y/N) _____ Do you have any learning barriers?(Y/N) _____ If yes, please explain. _____

Do you have any religious or cultural needs? (Y/N) _____ If yes, please explain. _____

PAST MEDICAL HISTORY (If you or someone in your family has had problems with any of the following conditions, please check the appropriate box(es). If you check family for any condition(s), please list their relationship to you.)

	Patient	Family		Patient	Family
Abnormal pap smears	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Gynecological Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancer(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Birth defects or inherited diseases	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
			Stomach, bowel or gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>
			Kidney or bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
			Lung disorder/asthma	<input type="checkbox"/>	<input type="checkbox"/>
			Headaches or nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
			Herpes exposure	<input type="checkbox"/>	<input type="checkbox"/>
			Blood clotting diseases, DVT or pulmonary embolus	<input type="checkbox"/>	<input type="checkbox"/>
			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

I authorize any holder of medical or other information about me to release to my insurance company or the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of Medical Insurance Benefits either to myself or the party who accepts assignment. Regulations pertaining to Medical Assignment of benefits apply.

SIGNATURE _____ **DATE** _____