

Patient History

Name _____
DOB ____/____/____
SS# _____

Pregnancy History

Total # of pregnancies: ____
of premature deliveries: ____
of miscarriages: ____
of abortions: ____
of living children: ____

Date of Delivery	Complications
_____	_____
_____	_____
_____	_____
_____	_____

History:

First day of last menstrual period: ____/____/____
Length of menstrual cycles (1st day of flow to next
Period 1st day of flow) ____ days
If heavy, how many pads per day? ____
Age at first period: ____
Pain with periods? Yes No
Problems with excess facial/body hair? Yes No
If yes, describe: _____
Problems with acne? Yes No
Are you sexually active? Yes No
If yes, list method of birth control/contraception:

Total number of sexual partners: ____
Do you have pain with intercourse? Yes No

Any history of sexually transmitted disease? Yes No

If yes, please circle:

Chlamydia Gónorrhèa Herpes
Syphilis PID HIV
Genital warts Hepatitis B
Trichomonas

Have you been tested for HIV?
Yes No

Any history of abnormal
Pap smears? Yes No
If yes, when? _____

Were you treated? Yes No
Method of treatment: _____

Any history of urinary tract infections?
Yes No

Problems with urination?
Yes No

Leakage of urine? Yes No
If yes, describe: _____

Any history of breast lumps?
Yes No

If yes, describe: _____

Have you ever had a Mammogram?
Yes No

If yes, when? _____
Normal Abnormal

Medications: Please list any medicines, birth control pills, or vitamins you are taking. Include any over the counter medications:

Do you have any *allergies* OR *adverse reactions* to medications or latex?

*****PLEASE COMPLETE BOTH SIDES OF THIS SHEET.**

Immunizations: Check those you have had, and note most recent year received.

Pneumonia _____ Tetanus _____
 Polio _____ Rubella _____
 Flu _____ Other _____

Hospitalizations: Please list serious illness, injuries or operations (exclude normal pregnancies):

Year	Reason/Hospital
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Prevention:

Do you smoke? **Yes No**
 How many packs a day? _____
 Do you drink alcoholic beverages? **Yes No**
 How many days a week? _____
 Do you drink coffee? **Yes No**
 How many cups a day? _____
 Do you use recreational drugs? **Yes No**
 Do you exercise? **Yes No**
 How many times a week? _____
 Type of exercise? _____

Do you have:
 A 'living will'? **Yes No**
 A Donor card? **Yes No**

Illnesses: Please check if you or members of your family have had any of the following problems:

YOU	FAMILY (relation to you)	
_____	_____	Alcoholism
_____	_____	Anemia
_____	_____	Asthma
_____	_____	Bleeding Disorder
_____	_____	Blood Clots
_____	_____	Cancer, Tumor
_____	_____	Depression
_____	_____	Diabetes
_____	_____	Domestic Violence
_____	_____	Drug Abuse
_____	_____	Eczema, Hives, Rashes
_____	_____	Epilepsy
_____	_____	Eye problems
_____	_____	Glaucoma
_____	_____	Heart Disease
_____	_____	High Blood Pressure
_____	_____	Kidney/Bladder problems
_____	_____	Liver Disease, Hepatitis
_____	_____	Jaundice (yellow)
_____	_____	Lung Disease
_____	_____	Mumps, Measles, or
_____	_____	Chicken Pox
_____	_____	Nervous Breakdown or
_____	_____	Mental Illness
_____	_____	Phlebitis
_____	_____	Rheumatic Fever
_____	_____	Rubella, German Measles
_____	_____	Stroke
_____	_____	Suicide Attempt
_____	_____	Thyroid Disease
_____	_____	Tuberculosis
_____	_____	Ulcer in Stomach or
_____	_____	Duodenum
_____	_____	Other Illnesses

 Patient signature Date

 Physician signature Date

*****PLEASE COMPLETE BOTH SIDES OF THIS SHEET**