Medical History

Name: ______________________________DOB: __________________Date: ______________________

Reason for Visit: ____________________________Primary Physician: ___________________________

Please list any medical/health problems:

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

Allergies to any Medication or Foods:______________________________Allergy to Latex:___________

Previous Surgeries (Include date

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

Family History

Number of Sisters_______Number of Brothers________

Heart Disease: Yes_____No_____Diabetes: Yes_____No_____Hypertension: Yes_____No_____

Whom: ______________________Whom: ___________________Whom: _____________________

Family Cancer: Breast: _____Ovarian: _____Colon: _____Prostate: _______Other type of Cancer__________

Relationship and Age____

Have you ever experience any of the following?

Anxiety: ____ Bipolar Disorder: ____ Depression: ____Suicidal Ideation: ____

Social History

Smoke:Yes___No___How many years?___How many packs per day?___When did you stop smoking___.

Alcohol: Yes _____No______ Frequency__________Sometimes___________Social________________.

Exercise: Yes _____No_____ Frequency__________ Sometimes ___________.

Do you have a spiritual practice: ____________________Religion: ____________?

Do you feel safe at home: Yes___________ No______________? Have ever been a victim of Domestic Violence from Spouse or Partner: Yes___________ No_______________?

What kind of work do you do? Profession: ________________ Retired: ________Student: ___________.

Signature_________________________________Date_________________________________

OB/GYN History

Name: _________________________________DOB: ___________________________Date: _____________

Age at first period: ___________years Last Menstrual Period: ___________Post-menopausal: _______

Menstrual Flow: Heavy: _____ Moderate: ______ Light: ________Duration: _______________________.

Are you Sexually Active? Yes_____ No______ Partners: Men, Women or Both_________________.

Number of Pregnancy: ______ Full Term: ______ Elective Abortion: ______

Preterm Deliveries: ______ C- Sections: ______ Ectopic: ______ Fetal Demise: _______

Have you had any difficulty becoming or keep any pregnancy? Yes ____ No____

Please list any complications you've had in your past pregnancies: ________________________________

____

Are you currently or have you use any form of contraceptive: Yes____ No____

Pills___ IUD____ Implants ____Condoms ____ Other _____

When was your last pap and how long ago? ________________________Normal ____Abnormal____

Are you currently or have you ever experience the following?

___ Colpo ___Cryo ___Leep ___Liver Problems ___Depression

___ Mammo ___PCOS ___STD ___Kidney Problems ___Frequency Urination

___ Excessive Menstruation Bleeding ___Pain with Intercourse(Dyspareunia)

Give the date of your last study, if you remember:

Blood Stool Test: __________ Tetanus: __________ Pneumonia Shot: __________

Flu Shot: __________ Hepatitis B Series: __________ Hepatitis A Series: __________

Signature___________________________________Date___________________________________