PATIENT HISTORY FORM

Patient Name:_____ Today's Date_____

DOB: _____ Reason for Visit_____

Married: _____ Employed:_____

GYN History: Please check all that apply:

[ ] Menopausal
If yes, year:_____

[ ]Hysterectomy
If yes, year _____

[ ] Ovaries removed
yes___no___

If you still have periods: Date of last menstrual period_____
Average length_____days

Average flow: (Heavy, Light, Moderate)

Do you pass clots? yes___no___

Do you have cramps?(Mild,Moderate,Severe)

Any Recent changes in periods?_____ What do you use for Birth Control?_____

Date of last Pap Smear_____ Have you ever had an Abnormal Pap Smear? _____

Date of Last Mammogram_____ Have you ever had an Abnormal Mammogram? _____

Date of Last Bone Density exam: _____

OB History: # of pregnancies_____ #of living children_____ #of vaginal deliveries_____

# of C-Section_____ #of miscarriages_____ # of abortions_____ # of ectopic pregnancies_____

Current Medications: Please list all current medications you are taking: _____

_____

Please list any medication allergies: _____

Social History: Please check all that apply

[ ] I have smoked in the past
For how long _____
Date stopped_____

[ ] I smoke currently
Packs per day_____
For how long_____

[ ] I drink
Drinks per week_____
Type of alcohol _____

[ ] I have a history of illicit drug use

Past Surgeries (please include date) _____

_____

Please fill out front and back

Your Past Medical History

Please check all that apply:

[ ] Asthma [ ]Kidney Infections/stones
[ ]Infertility [ ]HIV/AIDS
[ ]Heart Attack/Disease
[ ]Diabetes [ ]High Blood Pressure
[ ]Blood Clots [ ]Stroke
[ ]Eating Disorder [ ]Arthritis
[ ]Cancer (specify) _____
[ ]Stomach Disorder [ ]Anemia
[ ]Bowel Problems (specify)_____
[ ]Mental Illness [ ]Seizures
[ ]Hepatitis [ ]Liver Disease
[ ]Thyroid Disease [ ]Other _____

Family Medical History

Please specify relative
Diabetes _____
Heart Disease _____
Blood Clots _____
Stroke _____
High Blood Pressure _____
Osteoporosis_____
Alcohol/Drug Issues _____
High Cholesterol _____
Mental Illness _____
Cancer (specify)_____
_____
Mother Alive Deceased
Father Alive Deceased

REVIEW OF SYSTEMS

Please check all that currently apply to you:

Constitutional:
[ ] Unexplained weight loss
[ ] Fever
[ ] Extreme Fatigue
[ ] Change in Height

Cardiovascular:
[ ] Chest pain/pressure
[ ] Difficulty breathing on exertion
[ ] Swelling of legs
[ ] Rapid/Irregular heartbeat

Respiratory:
[ ] Shortness of breath
[ ] chronic cough

Gastrointestinal:
[ ] Frequent diarrhea
[ ] Bloody Stool
[ ] Frequent Nausea
[ ] Frequent Vomiting
[ ] Heartburn
[ ] Chronic Constipation
[ ] Involuntary loss of gas/stool

Musculoskeletal:
[ ] Joint Pain

Skin:
[ ]Rash
[ ]Moles (growth/changes)

Breasts:
[ ] Tenderness
[ ] Nipple discharge
[ ] Lump/Mass in breast

Neurologic:
[ ] Dizziness
[ ] Numbness
[ ] Frequent headaches

Psychiatric:
[ ] Depression
[ ] Anxiety

Genitourinary:
[ ] Blood in urine
[ ] Pain with urination
[ ] Strong urge to urinate
[ ] Frequent urination
[ ] Can not empty bladder
[ ] Involuntary urine loss
[ ] Lose urine with cough/lift
[ ] PMS
[ ] Pain with intercourse

Menopause:
[ ] Hot Flashes
[ ] Night Sweats
[ ] Sleep Disturbance
[ ] Vaginal Dryness
[ ] Mood Changes

GYN:
[ ] Bleeding after sex
[ ] Bleeding between periods
[ ] Pelvic Pain
[ ] Pain during or after sex
[ ] Vaginal Dryness