

**MEDICAL HISTORY**

Patient \_\_\_\_\_ Patient I.D.# \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Other source of Medical Care: \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_

**Contraception:** \_\_\_birth control pills \_\_\_depo injection \_\_\_condoms \_\_\_IUD \_\_\_diaphragm \_\_\_foam

Age menstruation began: \_\_\_\_\_ Average days flow: \_\_\_\_\_ Age at menopause: \_\_\_\_\_

**Date of last Pap:** \_\_\_\_\_ / \_\_\_\_\_ Results: \_\_\_\_\_

Have you ever had an abnormal Pap: Yes No Date: \_\_\_\_\_ Treatment: \_\_\_\_\_

**Pregnancy History:** Vaginal Deliveries: \_\_\_\_\_ C-Section: \_\_\_\_\_ Premature: \_\_\_\_\_

How many total: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Ectopic (tubal): \_\_\_\_\_ Abortions: \_\_\_\_\_

Medications: List all prescription or non-prescription medications taken in the past six months:

Do you drink more than two alcoholic drinks per day? Yes No If yes, how many per day: \_\_\_\_\_

Do you smoke: Yes No If yes, how many per day? \_\_\_\_\_ How long have you smoked: \_\_\_\_\_

Do you know your blood type? Yes No Type/Rh: \_\_\_\_\_

**ALLERGIES:** List all medications, food, plants, insects that cause a reaction:

**ILLNESS: Have you ever had any of the following listed below? Please circle all answers.**

- Yes No Anemia
- Yes No Arthritis
- Yes No Asthma
- Yes No Bacterial Vaginosis
- Yes No Bladder infection
- Yes No Blindness/fuzzy vision
- Yes No Blood clotting problem
- Yes No Breast disease/tumors
- Yes No Bronchitis
- Yes No Cancer
- Yes No Chest Pain/Angina
- Yes No Chicken Pox
- Yes No Chlamydia
- Yes No Cirrhosis
- Yes No Colitis
- Yes No Condyloma/HPV
- Yes No Diabetes
- Yes No Emphysema
- Yes No Appendectomy
- Yes No Endometriosis
- Yes No Epilepsy/convulsions
- Yes No Fainting spells
- Yes No Gall bladder disease
- Yes No Gall stones
- Yes No German measles
- Yes No Gonorrhhea
- Yes No Gout
- Yes No Heart attack
- Yes No Heart disease
- Yes No Heart murmur
- Yes No Hepatitis/Jaundice
- Yes No Herpes
- Yes No High blood pressure

- Yes No Kidney infection
- Yes No Kidney stones
- Yes No Leukemia
- Yes No Low blood pressure
- Yes No Migraine/headaches
- Yes No Mononucleosis
- Yes No Mumps
- Yes No Nervous Breakdown
- Yes No Painful/bloody urination
- Yes No Pelvic inflammation/PID
- Yes No Pelvic pain
- Yes No Phlebitis
- Yes No Polio
- Yes No Psychiatric treatment
- Yes No Rheumatic fever
- Yes No Sickle cell anemia
- Yes No Sinusitis
- Yes No Stroke
- Yes No Suicide Attempt
- Yes No Syphilis
- Yes No Thyroid Disease
- Yes No Trichomonas
- Yes No Tuberculosis
- Yes No Tumor/Uterine Fibroid
- Yes No Vaginal Infection
- Yes No Yeast Infection

Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- Has anyone in your family ever had any of the following?**
- Yes No Anemia
  - Yes No Bleeding Disorder
  - Yes No Breast Cancer
  - Yes No Diabetes
  - Yes No Epilepsy
  - Yes No Heart Disease
  - Yes No High blood pressure
  - Yes No Kidney disease
  - Yes No Mental Disorder
  - Yes No Stroke
  - Yes No Suicide
  - Yes No Tuberculosis/TB
- Other: \_\_\_\_\_

- Have you ever had any of the following:**
- Yes No Breast Surgery
  - Yes No Endometrial Ablation
  - Yes No Gall Bladder Removal
  - Yes No Hernia repair
  - Yes No Hysterectomy
  - Yes No Hysteroscopy
  - Yes No Laparoscopy
  - Yes No Myolysis
  - Yes No Myomectomy
  - Yes No HIV/HTLV III
  - Yes No Tubal Ligation
- Other: \_\_\_\_\_