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V 2.0

PATIENT HISTORY FORM (Please Print) Office Use Only: ID:

Last Name: First Name:

Primary Care Doctor: Reason for visit: ☐ Annual ☐ Problem

MENSTRUAL HISTORY

Last Menstrual Period: ☐☐ / ☐☐ / ☐☐

Age at 1st Menstrual Period: ☐☐ # Days: ☐☐

Frequency: # Weeks: ☐ or Irregular: (check) ☐

Menopause: ☐

Amount: (check) ☐ light ☐ normal ☐ heavy

Method of Birth Control (check one)

☐ Abstinence ☐ DepoProvera ☐ Oral contraceptives

☐ Condoms ☐ Early Withdrawal ☐ Tubal Ligation/ Vasectomy

☐ Contraceptive Patch/ring ☐ IUD ☐ Other

☐ None

MEDICAL/FAMILY HISTORY

Check problems you (P) or your family (F) have or had:

P	F		P	F	
☐	☐	Anemia	☐	☐	Kidney Stones
☐	☐	Arthritis	☐	☐	Hepatitis
☐	☐	Asthma	☐	☐	Lung Disease
☐	☐	Bladder Problems	☐	☐	Lupus
☐	☐	Clots in veins	☐	☐	Osteoporosis
☐	☐	Blood Transfusion	☐	☐	Reflux
☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Heart Disease	☐	☐	Thyroid
☐	☐	High Blood Pressure	☐	☐	Ulcers
☐	☐	High Cholesterol	☐	☐	Breast Cancer
☐	☐	Intestinal Disease	☐	☐	Ovarian Cancer
☐	☐	Irritable Bowel Syndrome	☐	☐	Uterine Cancer
☐	☐	Kidney Disease	☐	☐	Colon Cancer
			☐	☐	Other Cancer

SEXUAL HISTORY

Age of first sexual Intercourse ☐ < 18 yrs old ☐ > 18 yrs old

# of sexual partners ☐ 3 or less ☐ 4 or more

Sexual activity: ☐ Never ☐ Females ☐ Males ☐ Both

GYNECOLOGIC HISTORY (Month/year)

Last pap smear: ☐☐ / ☐☐☐☐

Last Mammogram: ☐☐ / ☐☐☐☐

Check problems you have or had:

☐ Abnormal pap smears ☐ Infertility

☐ Endometriosis ☐ Painful Periods

☐ Fibroids ☐ Sexually Transmitted Diseases

OBSTETRICAL HISTORY (List number of pregnancies)

☐ # Preterm Vag Deliveries ☐ # Preterm C-Sect Deliveries ☐ # Miscarriages

☐ # Full term Vag Deliveries ☐ # Full term C-Sect Deliveries ☐ # Elective Terminations

SURGICAL HISTORY Check all that apply:

☐ Appendectomy ☐ Gall Bladder ☐ Tonsillectomy

☐ D & C ☐ Hysterectomy ☐ Other

MEDICATIONS

☐ None ☐ Blood Pressure ☐ Hormones

☐ Anti-Depressant ☐ Diabetes ☐ Thyroid

☐ Contraceptive ☐ Heart ☐ Other

DRUG ALLERGIES

☐ None ☐ Penicillin ☐ Other

☐ Codeine ☐ Shellfish

SOCIAL HISTORY

Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Employed: ☐ Yes ☐ No

Cigarettes per day: ☐☐ (Check if Yes)

Alcohol drinks per wk: ☐☐ Substance Abuse ☐

Seatbelt use ☐

Exercise: ☐ Yes ☐ No Physical/Sexual Abuse ☐

CURRENT/PREVIOUS MEDICAL CONCERNS

(check all that apply; (C) Current (P) Previous)

C	P		C	P	
☐	☐	Weight change	☐	☐	Bleeding between periods
☐	☐	Fever/chills	☐	☐	Heavy vaginal bleeding
☐	☐	Difficulty sleeping	☐	☐	Vaginal discharge
☐	☐	Eyes	☐	☐	Low sex drive/ sexual dysfunction
☐	☐	Hearing loss	☐	☐	Recurrent yeast infections
☐	☐	Sinus congestion	☐	☐	Painful intercourse
☐	☐	Chest pain/palpitations	☐	☐	Pelvic pain
☐	☐	Cough/wheezing/ difficulty breathing	☐	☐	Skin rashes
☐	☐	Bloody sputum	☐	☐	Breast pain/discharge/mass
☐	☐	Nausea/vomitting	☐	☐	Seizures
☐	☐	Diarrhea	☐	☐	Fainting episodes
☐	☐	Constipation	☐	☐	Mood changes/depression/ Anxiety
☐	☐	Bloody stools	☐	☐	Heat/cold intolerance
☐	☐	Frequent urination	☐	☐	Excessive thirst or urination
☐	☐	Painful/blood urination	☐	☐	Hot flashes
☐	☐	Leakage of urine	☐	☐	Abnormal bruising/bleeding

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