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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)

Amount: (check) light normal heavy

Menopause:

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:

Alcohol drinks per wk:

Exercise: Yes; No

(Check if Yes)

Substance Abuse; Seatbelt use; 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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Do you accept blood transfusion in emergency? Y/N