PATIENT HISTORY

Name:	Date of Birth:	Today's Date:
Address:		
Home Phone:	Work Phone:	Cell Phone:
Please leave a phone number where a personal message can be left:		
Emergency Contact:	Relationship:	Phone:
Primary Care Physician:	Phone:	
Occupation:	Marital Status:	SSN:
Referred by:	Insurance:	
Reason for visit:		

GYN HISTORY

Last Menstrual Period:	Have you ever had any of the following sexually transmitted diseases? Please Check .	
Previous Menstrual Period:	☐	Chlamydia
Age at 1st Menses:	☐	Gonorrhea
Menstrual Interval (Days)	☐	Herpes
Menstrual Flow (Days)	☐	Human Papilloma Virus (HPV)
Are you sexually active?	☐	Human Immunodeficiency Virus (HIV)
Sexual Preference: ☐ Male ☐ Female ☐ Both	☐	Syphilis
Age at 1st Intercourse:	☐	Trichomonas
Lifetime # of sexual Partners:	☐	Pelvic Inflammatory Disease
Current Contraception:		
Past Contraception:	Other:	
Have you ever been sexually abused? ☐ Yes ☐ No		
Last Pap Smear:		
Have you ever had an **abnormal** Pap? ☐ Yes ☐ No		
Have you ever had a Cone biopsy or LEEP procedure?		
Last Mammogram:		
Any Breast Biopsies or Breast Surgeries?		

OBSTETRIC HISTORY

Total number of pregnancies:	Miscarriages:	Abortions:	Ectopics:

#	Birth Date	Weeks at Delivery	Baby's Sex	Weight	Type of Delivery	Complications

SURGICAL HISTORY

Pleas list any previous surgeries with date of procedure:

NAME_____Date_____

MEDICAL HISTORY

Please Check if you have ever had any of the following:		
☐	Asthma	
☐	Pneumonia	
☐	Tuberculosis	
☐	Kidney Infection/Stone	
☐	Headaches	
☐	Seizures	
☐	High Blood Pressure	
☐	Diabetes	
☐	Stroke	
☐	Blood Clots in Lungs or Legs	
☐	Rheumatic Fever	
☐	Heart Problems	
☐	Cancer	
☐	Depression	
☐	Eating Disorder	
☐	Glaucoma or Cataracts	
☐	Ulcers	
☐	Hepatitis	
☐	Anemia	
☐	Blood Transfusions	
☐	Arthritis	
☐	Broken Bones	
☐	Collagen Vascular Disease(Lupus)	
☐	Thyroid Disease	
☐	Chicken Pox	Have you been vaccinated?
☐	Other	

MEDICATIONS

Please list all medications you are **currently t**aking:

ALLERGIES

Are you allergic to any medications? Please list:

FAMILY HISTORY

Has anyone in **your family** had any of the following diseases?					
☐	**Illness**	**Family Member**	☐	**Illness**	**Family Member**
☐	Diabetes		☐	HIV	
☐	Stroke		☐	Tuberculosis	
☐	Heart Disease		☐	Birth Defects	
☐	Blood Clots in Lungs or Legs		☐	Breast Cancer	
☐	High Blood Pressure		☐	BRCA gene mutation	
☐	High Cholesterol		☐	Ovarian Cancer	
☐	Osteoporosis		☐	Uterine Cancer	
☐	Hepatitis		☐	Colon Cancer	
			☐	Other	

Name_____Date_____

SOCIAL HISTORY

Please check all that apply					
☐	Smoking	Packs per day		How many years?	
☐	Alcohol: Drinks per day	Drinks per week		How many years?	
☐	Recreational Drug Use				
☐	Seat Belt Use	☐	Regular Exercise	☐	Health Hazards at Home or Work

REVIEW OF SYSTEMS

Please check if you **currently** have any of the following problems:					
Constitutional			**Genitourinary**		
☐	Weight loss		☐	Pain with Urination	
☐	Weight gain		☐	Strong Urgency to Void	
☐	Fever		☐	Frequent Urination	
☐	Fatigue		☐	Incomplete Emptying	
☐	Change in Height		☐	Involuntary Loss of Urine	
Eyes			☐	Abnormal Bleeding	
☐	Double Vision		☐	Painful Periods	
☐	Spots Before Eyes		☐	Painful Intercourse	
☐	Vision Changes		☐	Infertility	
☐	Glasses/Contacts		☐	Abnormal Vaginal Discharge	
Ear, Nose, and Throat			**Muskuloskeletal**		
☐	Earaches		☐	Joint Pain	
☐	Ringing in Ears		☐	Muscle Weakness	
☐	Hearing Problems		**Skin**		
☐	Sinus Problems		☐	Rash	
☐	Sore Throat		☐	Sores	
☐	Mouth Sores		☐	Changing Moles	
☐	Dental Problems		**Breasts**		
Cardiovascular			☐	Lumps	
☐	Painful Breathing		☐	Nipple Discharge	
☐	Chest Pain or Pressure		**Neurologic**		
☐	Difficulty breathing on exertion		☐	Seizures	
☐	Swelling of Legs		☐	Numbness	
☐	Rapid or Irregular Heart Beat		☐	Trouble Walking	
Respiratory			☐	Frequent or Severe Headaches	
☐	Wheezing		**Psychiatric**		
☐	Spitting up Blood		☐	Depression	
☐	Shortness of Breath		☐	Anxiety	
☐	Chronic Cough		**Endocrine**		
Gastrointestinal			☐	Abnormal Hair Growth	
☐	Frequent Diarrhea		☐	Heat or Cold Intolerance	
☐	Bloody Stool		☐	Abnormal Thirst	
☐	Nausea or Vomiting		☐	Hot Flashes	
☐	Constipation		**Hematologic/Lymphatic**		
☐	Involuntary Loss of Stool		☐	Frequent Bruises	
Genitourinary			☐	Cuts Do Not Stop Bleeding	
☐	Blood in Urine		☐	Enlarged Glands	

Completed by: Patient ☐ Physician ☐ Nurse ☐ Date reviewed with Patient:_____

Patient Signature_____Physician Signature_____

Annual Review of History: Date_____Signature_____

Date_____Signature_____

Date_____Signature_____

Date_____Signature_____