Patient Medical History

Patient name _____ Birthdate_____ Age _____

Last *First* *Middle initial*

List all the medications, vitamins and supplements you are currently taking:

Medication Name	Dose	How Long
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7. _____	_____	_____
8. _____	_____	_____

Allergies

Medication/material name	Adverse reaction
_____	_____
_____	_____
_____	_____
_____	_____

Pharmacy Information

Pharmacy Name _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Mail Order Pharmacy Name_____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Patient Name: _____ DOB: _____ MRN #: _____

OBSTETRICAL HISTORY (Please list all pregnancy outcomes including miscarriage, ectopic, abortions and stillbirths)

Year	Gestational Age (weeks)	Delivery Mode	Complication/Procedures
_____	_____	Vaginal Cesarean VBAC Vacuum/Forceps	_____
_____	_____	Vaginal Cesarean VBAC Vacuum/Forceps	_____
_____	_____	Vaginal Cesarean VBAC Vacuum/Forceps	_____
_____	_____	Vaginal Cesarean VBAC Vacuum/Forceps	_____
_____	_____	Vaginal Cesarean VBAC Vacuum/Forceps	_____
_____	_____	Vaginal Cesarean VBAC Vacuum/Forceps	_____

GYNECOLOGICAL HISTORY

Menses: LMP (1st day of last period): _____

Age at first period? _____ Are you periods regular? Yes No Any recent changes in your period? Yes No

Flow? Light Medium Heavy Other _____ Do you spot or bleed between periods? Yes No

Typical cycle length (day 1 of period to day 1 of next period)? 21-24 25-28 29-32 >35 days apart

Period duration? 1-3 days 3-5 days 5-8 days > 8 days

Menopause: Age: _____ HRT: Yes No How long: _____ months/years

Type (circle all that apply): Topical Bioidentical Traditional Name: _____

Sexual History: Are you currently sexually active? Yes No Number of lifetime sexual partners (lifetime)? _____

Sexual preference? Heterosexual Homosexual Other _____

Contraception method (circle all that apply): *Abstinence None Rhythm/Natural Family Planning Condoms Pills Patch Vaginal ring Implantable Progesterone IUD Permanent sterilization Vasectomy Other*_____

Pap History: Last Pap smear year? _____ Have you ever had an abnormal Pap smear? Yes No When? _____

Have you ever had colposcopy? Yes No Any cervical procedures? Yes No What procedure? _____

Have you received the HPV vaccine? Yes No What age?_____ Did you complete the vaccine series? Yes No

STI History: (circle all that apply)? *Gonorrhea Chlamydia Genital warts/HPV Herpes HIV Syphilis Trichomoniasis Hepatitis Pelvic Inflammatory Disease (PID) Zika Ebola Other:* _____

Patient Name: _____ DOB: _____ MRN #: _____

Have been diagnosed with any Gynecologic conditions? If so, what? _____

Any travel outside of the US? Yes No Zika related country, if so where? _____ When? _____

Last breast imaging date _____ Results? _____

Have you had any genetic testing? Hereditary cancer testing, Carrier testing, Cystic Fibrosis, other?

Results? _____ Do you have a copy of your results? Yes No

PAST MEDICAL HISTORY (any medical issue you have been diagnosed with)

Medical Condition	Duration of Treatment	Currently treated
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5. _____	_____	_____
6._____	_____	_____

SURGICAL HISTORY Please list ALL surgeries and dates

Procedure	Year	Reason
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____

Have you had general anesthesia? Yes No

Have you had any problems with anesthesia? Yes No Describe _____

Have you ever received a blood transfusion or blood products? Yes No Would you? Yes No

Patient Name: _____ DOB: _____ MRN #: _____

FAMILY HISTORY

Cancers (Breast, Ovarian, Colon, Uterine, Other)	Age at diagnosis	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family history of Hypertension, Heart Attack, Stoke, Diabetes, Osteoporosis, Mental Illness, other? Specify condition

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Marital status? Married Divorced Separated Widowed Engaged Other _____

Occupation? _____ Student? Yes No School: _____

Exercise? Yes No Daily 5x week 3x week <3x week Type of exercise? _____

Any diet restrictions? _____ Alcohol consumption? None <3x week 3-5x week Daily

Have you ever used tobacco? Yes No How much? _____ How many years? _____

Any drug use? Prescription pain medications_____ Marijuana Cocaine Heroin Crystal Meth other? _____

History of abuse? Yes No Type (circle all that apply): Domestic Emotional Sexual Other: _____