Patient History Form – This is a confidential record and will be kept in your doctor's office. Information contained on this form will not be released without your permission.

Name: DOB: Age: Today's Date:
(Previous Name)

Reason for Visit

Past Medical History Have you ever had any of the following?

Anemia	Y N	Heart Disease	Y N	High Blood Pressure	Y N
Mitral Valve Prolapse	Y N	Genital Herpes	Y N	Blood Transfusion	Y N
Freq. Bladder Infection	Y N	Gonorrhea/Chlamydia	Y N	Seizures	Y N
Migraines	Y N	Liver Disease	Y N	Depression/Anxiety	Y N
Drug/Alcohol Problems	Y N	Asthma	Y N	Diabetes	Y N
Blood Clots Leg/Lung	Y N	Thyroid Problems	Y N	HPV	Y N
Cancer _____					

Allergies to medication Y N Please List _____
Allergies to Latex Y N

Current Medications and Dosage

Previous Surgeries

Past Gynecological History

Menopausal Y N Age of Menopause _____
Age of First Period:_____
If Not Menopausal:
Periods Regular Y N Cycle Length _____ Number Of Days_____
Flow: Light____Moderate____Heavy____ Pain or Cramping Y N Method of Birth Control_____

Past Obstetrical History please list all pregnancies in order including miscarriages, premature births, terminations, etc.

Year	Sex	Weight	Type of Delivery	Weeks Pregnant	Anesthetic	Complications

Social History

Are you Sexually Active Y N Abnormal Pap Y N
Have you been treated for Abnormal Pap Y N List Treatment_____
Do you Smoke Y N How Much How Long Date Quit
Do you Drink Alcohol Y N How Much How Long
Do you use Street Drugs Y N If Yes please list

Family History

Has any relative ever had any of the following, please place the corresponding letter behind the condition

M - Mother F - Father S - Sister B - Brother MGM – Maternal Grandmother MGF – Maternal Grandfather
MA- Maternal Aunt MU- Maternal Uncle PGM – Paternal Grandmother PGF - Paternal Grandfather
PA – Paternal Aunt PU – Paternal Uncle

Breast Cancer	Y	N	Who	Age	Cervix Cancer	Y	N	Who	Age
Uterine Cancer	Y	N	Who	Age	Ovarian Cancer	Y	N	Who	Age
Diabetes	Y	N	Who	Age	High Blood Pressure	Y	N	Who	Age
Heart Disease	Y	N	Who	Age	Stroke	Y	N	Who	Age

Please List
Other Cancer_____ Inherited Disease_____

Review of Systems

Genitourinary

Vaginal Discharge	Y	N
Abnormal Bleeding	Y	N
Painful Periods	Y	N
Painful Intercourse	Y	N
Fibroids	Y	N
Infertility	Y	N
Urine Leakage	Y	N
Frequent Bruising	Y	N
Frequent Urination	Y	N
Burning Urination	Y	N

Cardiovascular

Chest Pain	Y	N
Difficulty Breathing	Y	N
Cough	Y	N
Palpitations	Y	N

Breast

Nipple Discharge	Y	N
Lumps	Y	N
Pain	Y	N
Skin Changes	Y	N

Gastrointestinal

Nausea/Vomiting	Y	N
Diarrhea	Y	N
Abdominal Pain	Y	N

Respiratory

Wheezing	Y	N
Shortness of Breath	Y	N
Sleep Apnea	Y	N

Endocrine

Hair Loss	Y	N
Hot Flashes	Y	N

Hematologic/Lymphatic

Swollen Glands	Y	N
Urine Retention	Y	N
Constipation	Y	N

Psychiatric

Depression/Crying	Y	N
Anxiety	Y	N
Thoughts of Suicide	Y	N
Swelling	Y	N

Additional Comments/Concerns