HEALTH HISTORY

Name: _____ Age: _____ Date of Birth: _____

Today's Date: _____ Reason for visit today: _____

ALLERGIES

List any allergies you have to medications:

_____

_____

_____

What is your preferred pharmacy? _____

Location (street and city): _____

_____

MENSTRUAL HISTORY

First day of last menstrual period: _____

Date of last pap: _____

Date of last mammogram: _____

TOBACCO HISTORY

Do you use tobacco? ☐ Yes ☐ No ☐ Quit

Quit date: _____

MEDICATIONS

List all medications you are currently taking:

Name	Dosage	Frequency	Start Date

GYNECOLOGIC HISTORY

Are your menses: ☐ regular/monthly ☐ irregular ☐ no menses due to _____

Cycles occur approximately every _____ days

Average days of flow: _____

Do you have pain with menses? ☐ Yes ☐ No

Age of first menses _____

Do you use hormone replacement? ☐ Yes ☐ No

Duration of hormone use: _____

Have you ever had sexual activity? ☐ Yes ☐ No

Your sexual partner(s) are: ☐ Male ☐ Female

Are you sexually active currently? ☐ Yes ☐ No

Do you have pain with sexual activity? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No

Do you use any method of contraception?

Currently use: _____ Have previously used: _____

Have you had an abnormal Pap or HPV test result? ☐ Yes ☐ No What month/year? _____

Have you ever had a LEEP, cone, or other treatment for an abnormal pap? ☐ Yes ☐ No When? _____

Have you received the vaccination for human papillomavirus (Gardasil)? ☐ Yes, all 3 shots ☐ Partially complete ☐ No

Have you ever had:

☐ Fibroids ☐ Endometriosis ☐ Ovarian cysts ☐ Infertility

☐ Sexually transmitted infection ☐ Genital herpes ☐ History of domestic violence ☐ Sexual abuse

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Name: _____ Date of Birth: _____

PREGNANCY HISTORY

Pregnancies _____ # Deliveries _____ # Miscarriages _____
Ectopics _____ # Stillbirths _____ # Abortions _____

List deliveries you have had, and any complications:

Month/Year	Vaginal or C/S	Sex	Birth Weight	Any complications during pregnancy or delivery?

MEDICAL HISTORY

Have you ever had:

- ☐ High blood pressure
- ☐ Bladder / kidney problems
- ☐ Diabetes
- ☐ Neurological problems
- ☐ Autoimmune disease
- ☐ Anemia
- ☐ Chickenpox
- ☐ Asthma / lung problems
- ☐ Heart disease
- ☐ Stomach / intestinal problems
- ☐ Thyroid problems
- ☐ Seizures / Epilepsy
- ☐ Lupus
- ☐ Blood transfusions
- ☐ Cancer – type of cancer: _____
- ☐ Other: _____
- ☐ High cholesterol or triglycerides
- ☐ Liver problems / hepatitis
- ☐ Depression or anxiety
- ☐ Migraine headaches
- ☐ Rheumatoid Arthritis
- ☐ Blood clots in deep vein or lung

Comments on medical history: _____

SURGICAL HISTORY

List any surgeries or procedures you have had:

Type of Surgery	Month / Year

FAMILY HISTORY

List any family members who have had these conditions, and age at diagnosis:

- ☐ Breast cancer _____
- ☐ Uterine cancer _____
- ☐ Other cancer _____
- ☐ Ovarian cancer _____
- ☐ Colon cancer _____

Any family history of the following conditions?

- ☐ Diabetes
- ☐ Hypertension
- ☐ Osteoporosis
- ☐ Birth defects
- ☐ Blood clots in a deep vein or lung
- ☐ Mental retardation or developmental delay

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No Average number of drinks per week? _____
Do you use recreational drugs? ☐ Yes ☐ No Have you ever used IV drugs? ☐ Yes ☐ No