Patient Medical History Form

Name: _____ Age: _____ DOB: _____

Marital Status: S□ M□ D□ W□ Occupation: _____

Referred by: _____ Primary Care Provider: _____

Reason for visit: _____

Medical History:

Have you ever been treated for any medical problems? Yes□ No□

Please circle any that apply:

Anemia	Ulcer	Heart Disease
Migraines	High Blood Pressure	Thyroid disease
Stroke	Bladder Infections	Rheumatic Fever
Diabetes	Blood clots	Psychiatric Problems
Heart Murmur	Kidney Stones	Liver Problems
Cancer	Seizures	Breast Problems / Biopsies
Asthma	High Cholesterol	Stomach/Bowel Problems
HIV	Other: _____	

Have you ever been hospitalized? Yes□ No□

If yes, please list dates and reasons:

_____

_____

_____

Have you ever had any surgeries? Yes□ No□

If yes, please list dates and procedures:

_____

_____

_____

Have you ever had a blood transfusion? Yes□ No□

If yes, what was the reason?_____

Do you take antibiotics prior to procedures such as dental visits? Yes□ No□

Allergies to Medications:

Name of medicine and reaction: _____

Name of medicine and reaction: _____

Name of medicine and reaction: _____

Name of medicine and reaction: _____

Are you allergic to Latex? Yes□ No□ Reaction:_____

Current Medications including over the counter medications:

Name: _____	Dose: _____	How often: _____
Name: _____	Dose: _____	How often: _____
Name: _____	Dose: _____	How often: _____
Name: _____	Dose: _____	How often: _____
Name: _____	Dose: _____	How often: _____
Name: _____	Dose: _____	How often: _____
Name: _____	Dose: _____	How often: _____

Gynecologic History:
Month/Yr : Last pap smear: _____ Last mammogram: _____ Last bone density: _____
Age at first period: _____ Age at menopause: _____
Have you ever had an abnormal pap smear? Yes☐ No☐
If yes, when, and what treatment did you have? _____
Have you ever been told that you have any of the following? Please circle:
Endometriosis Ovarian cysts Fibroids

Menstrual History:
Number of days between periods (1st day to 1st day of next period): _____
Number of days of bleeding: _____ Light☐ Moderate☐ Heavy☐ Pain ☐
Do you have any bleeding between your periods? Yes☐ No☐
Are you currently sexually active? Yes☐ No☐
Do you have any vaginal bleeding after intercourse? Yes☐ No☐
Do you have pain with intercourse? Yes☐ No☐
Age at first intercourse: _____

What forms of birth control have you used in the past? Please circle:

Oral contraceptives (pills)	Rhythm	Depo-provera
Condoms	Diaphragm	Norplant
Ortho-evra (patch)	Cervical cap	IUD
Spermicides	Tubal ligation	Withdrawal
Partner has vasectomy	Nuvaring	

What form of birth control are you using now? _____

Have you ever had any sexually transmitted infection? Yes☐ No☐ Please circle:

Gonorrhea	Chlamydia	Syphilis	Genital warts
Trichomonas	Genital herpes	HPV	PID

Sexual preference: Men☐ Women☐ Both☐

Pregnancy History:
# of pregnancies: _____ Living children: _____ Miscarriages: _____
Abortions: _____ Ectopics (tubal): _____

Social History:
Do you smoke? Yes☐ No☐
Do you drink alcohol? Yes☐ No☐ If yes, how many drinks per week? _____
Do you use any recreational drugs? Yes☐ No☐ If yes, which ones? _____
Do you have a history of domestic violence or sexual abuse? Yes☐ No☐
Do you exercise regularly? Yes☐ No☐

Family History:
Has anyone in your family had any of the following: (if yes, please note relationship)
Breast Cancer: Yes☐ No☐ _____
Uterine Cancer: Yes☐ No☐ _____
Ovarian Cancer: Yes☐ No☐ _____
Colon Cancer: Yes☐ No☐ _____
Stroke: Yes☐ No☐ _____
Diabetes: Yes☐ No☐ _____
Blood Clotting problems: Yes☐ No☐ _____
High blood pressure: Yes☐ No☐ _____
Heart Attack: Yes☐ No☐ _____
Thyroid Disease: Yes☐ No☐ _____

Is there anything else that you feel we should know? _____
_____