Medical Information

Patient Name	DOB	Age:

Reason for your visit today:	How long have you had this problem?

Medical History

Age at first period?	Do you have regular monthly periods? Yes No	How often does your period come?

Periods are: Mild Moderate Heavy	First Day Last Menstrual Period	Cramps: Yes No If yes, Mild Moderate Severe

Current Birth Control:	Are you happy with your birth control? Yes No	Sexual Orientation:	Marital Status:

Do you have Fibroids? Yes No	Do you have ovarian cyst? Yes No	Do you have endometriosis? Yes No

Are you sexually active?	Last Pap Smear: ____/____	Have you ever had an abnormal Pap?	If yes, please give year and any procedures:

Last Mammogram: ____/____	Have you ever had and abnormal Mammogram?	If yes, please give year and any procedures:

Last Colonoscopy: ____/____	Last Bone Density ____/____

Allergies:	Reaction:

Medical History Continued….

Medications	Dosage

Smoking History: Do you currently smoke?______ If yes, ________packs/day Have you ever smoked?________ If yes, ________ packs/day	Do you currently use alcohol beverages? Yes No Have you ever used alcohol beverages? Yes No Have you ever used recreational drugs? Yes No Do you currently use recreational drugs? Yes No	Do you do monthly breast exams? Yes No Do you currently exercise regularly? Yes No
Anemia Yes No	Blood Transfusion Yes No	COPD Yes No
Blood Clots Yes No	Leukemia Yes No	Pneumonia Yes No
Varicosities Yes No	RH Disease Yes No	Arthritis Yes No
Stroke Yes No	Epilepsy Yes No	Lupus Yes No
Depression Yes No	Anxiety Yes No	Cytomegalovirus Yes No
Multiple Sclerosis Yes No	Asthma Yes No	Rubella Yes No
Chicken Pox Yes No	MRSA Yes No	Heart Disease Yes No
Hypertension Yes No	Rheumatic Fever Yes No	Hepatitis Yes No
Gallbladder Disorder Yes No	Crohns Yes No	Peptic Ulcer Yes No
Colitis Yes No	Renal Disease Yes No	Chronic UTI's Yes No
Diabetes Yes No	Thyroid Disorder Yes No	Osteoporosis Yes No
Scoliosis Yes No	Cancer Yes No If so, what type?	Glaucoma Yes No
HIV/AIDS Yes No	Chlamydia Yes No	Gonorrhea Yes No
Syphilis Yes No	Genital Herpes Yes No	HPV Yes No
Group B Streptococcus Yes No	Trichomoniasis Yes No	Tuberculosis Yes No

Family Medical History	
Are you adopted? Yes No	Are you of Jewish Decent? Yes No

Please check all that apply under the appropriate family member: (For brother and sister please list which sibling or both)
Please list Age

	Self	Age	Parents/ Siblings/ Children	Age	Relatives on Mother's side	Age	Relatives on Father's	Age
Breast Cancer								
Ovarian Cancer								
Uterine Cancer								
Colon/Rectal Cancer								
Other Cancer (Specify cancer type)								
High Cholesterol								
Osteoporosis								
Birth Defects								
Diabetes								
Gestational Diabetes								
Hypertension								
Hypertension in Pregnancy								
Heart Disease								

Reproductive History

Total # of Pregnancies	Full term births	Premature births	Spontaneous Abortions	Induced Abortions	Ectopic	Stillbirths	Living

Date	Months	Infant weight	Sex	Delivery Type (Vaginal or Cesarean):	Anesthesia Received (i.e. Epidural):	Complications	Location

Surgical History

Have you had any of the following surgeries?	
Oral: Yes No	If so, What and When?
Abdominal: Yes No	If so, What and When?
Breast: Yes No	If so, What and When?
Gynecological: Yes No	If so, What and When?
Orthopedic: Yes No	If so, What and When?
Cardiac: Yes No	If so, What and When?
Spinal: Yes No	If so, What and When?
Other: Yes No	If so, What and When?