To facilitate your visit, please fill out this form regarding your medical history and any current problems.

Name ________________________________ Date ____________________________________

Age __________________________________ Marital Status _____________________________

Occupation ____

What concerns or problems do you have to discuss with your doctor today?

First day of your last menstrual period ___________________
How often do you have your period? ____________________ Is your period painful? ____________
Age you started your period _________ Have you gone through menopause? ________ age _____
Are you currently sexually active? ____

Do you have any allergies to any medications?

Current medications and dosage (including over the counter and herbal supplements)?

How many of each (including current pregnancy)?

Total pregnancies _______ Term Births ___________ Pre-Term Births ______________
Live Births ______________ Stillbirths _____________ Miscarriages _________________
Abortions ______________ Ectopic _______________ Twins/Triplets ________________
Living Children __________

	Pregnancy 1	Pregnancy 2	Pregnancy 3	Pregnancy 4	Pregnancy 5	Pregnancy 6	Pregnancy 7
Date of Birth / Miscarriage							
Weeks Gestation							
Gender							
Birth Weight							
Vaginal or C-Section							

Complications or Medical Conditions? ____
Last Pap Smear _________________________ Any Abnormal Paps? ___________________________
Last Mammogram ______________________ Last Bone Density Test _________________________
Last Colonoscopy ______________________
What do you use for Birth Control? ____

Medical History

	Yes	No	Comments		Yes	No	Comments
Abnormal Pap Smear				Heart Attack			
Anemia				Heavy Periods			
Anxiety				High Blood Pressure			
Arthritis				High Cholesterol			
Asthma				Infertility			
Blood Transfusion				Incontinence			
Cancer				Kidney Disease			
Depression				Osteoporosis			
Diabetes				Seizures			
Endometriosis				Stroke			
Fibroids in Uterus				Thyroid Disease			
GERD				Ulcers			

Other: ____

If yes, please explain: ____

____

Surgical History

	Yes	No	Comments		Yes	No	Comments
Appendectomy				Fracture Surgery			
Brain Surgery				Hernia Repair			
Breast Augmentation				Hysterectomy			
Breast Surgery				Joint Replacement			
Gallbladder				Laparoscopy			
Colon Surgery				Ovary Removal			
C-Section				Tonsils Removed			
Cosmetic Surgery				Treatment to Cervix			
Endometrial Ablation				Tubes Tied			
Eye Surgery				Other			

Other: ____

Family History

Relationship	Alive or Deceased	Alcohol/Drug Abuse	Asthma	Clotting Disorder	Breast Cancer	Cancer	Colon Cancer	Diabetes	Heart Attack	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Chromosome Disorder / Learning Deficit	Ovarian Cancer	Stroke	Other
Paternal Grandfather																	
Paternal Grandmother																	
Maternal Grandmother																	
Maternal Grandfather																	
Father																	
Mother																	
Brother																	
Sister																	
Daughter																	
Son																	

Social History

	Type	Yes	No
Alcohol Use			
Sexually Active			
Drug Use			
Tobacco Use			
Number of Years			
Number of Packs/Day			
Caffeine Use			

Thank you for completing this form.
Please return it to the receptionist and we will be with you shortly.