

PATIENT HISTORY FORM



Please help us by giving some information about your health. Please complete both sides and fill in all spaces. **Please print.**

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Primary Care Doctor: _____

Other physicians treating you: _____

Current medications: _____

Medication allergies: _____

Other allergies: _____ Latex allergy: Yes No

Reason for your visit: _____

Past GYN History

Last menstrual period: _____ Age when periods began: _____

Length of periods: _____ How many days between periods? _____

Do you do self breast exams? Yes No

Last Pap Smear: _____ Result: _____

Last Mammogram: _____ Result: _____

Last Bone Density Test: _____ Result: _____

Last Colonoscopy: _____ Result: _____

Current birth control/family planning method: _____ Are you trying to get pregnant? _____

How many sexual partners in the past year: _____ Are you sexually active? Yes No

Past OB History

Total pregnancies: _____ Number of living children: _____

Number of miscarriages: _____ Number of voluntary terminations: _____

Number of C-Sections: _____ Number of vaginal deliveries: _____

Number of tubal pregnancies: _____

Complications: _____

Social History

Do you smoke? Yes No

Comments: _____

Amount per day: _____

Comments: _____

Do you drink alcohol? Yes No

Comments: _____

Amount per day? _____

Comments: _____

Have you used drugs? Yes No

Comments: _____

Do you exercise? Yes No

Comments: _____

Do you use a seat belt? Yes No

Comments: _____

Have you been emotionally, sexually, or physically abused? Yes No

Comments: _____

Medical problems (such as diabetes, high blood pressure, thyroid problems or problems with heart, lung or kidney)?

Any past surgeries? _____

Regarding your health, please review the following list of health problems and describe any “yes” answers:

	Y	N		Y	N		Y	N
General/Constitutional			Gastrointestinal			Musculoskeletal		
Fatigue			Rectal pain			Arthritis		
Fever			Hemorrhoids			Back pain		
Weight gain			Hernia			Leg pain		
Weight loss			Indigestion			Pain in joints		
Ophthalmologic			Abdominal pain			Peripheral Vascular		
Vision changes			Blood in stool			Swelling in legs/feet		
Cataracts			Constipation			Skin		
Glaucoma			Diarrhea			Hair loss		
ENT			Nausea			Venereal warts/Herpes		
Hearing loss			Vomiting			Mole(s)		
Balance problems			Hematology			Rash		
Hoarseness			Chemotherapy			Skin cancer		
Difficulty swallowing			Anemia			Neurologic		
Sore throat			Blood disorders			Lupus		
Endocrine			Easy bruising			Stroke		
Thyroid problems			Women Only			Memory problems		
Hormone imbalance			Chlamydia/Conorrhea			Dizziness		
Diabetes			Vaginal odor			Fainting		
Steroids			Nipple discharge			Headache		
Respiratory			Breast lump			Seizures		
Difficulty breathing			Breast pain			Psychiatric		
Chronic cough			Heavy periods			Depression		
Blood in sputum			Hot flashes			Phobias		
Cardiovascular			Pain with intercourse			Anxiety		
Chest pain			Vaginal discharge					
High cholesterol			Genitourinary					
Irregular heartbeat			Blood in urine					
Shortness of breath			Pain with urination					
			Urgency					
			Frequency					
			Involuntary loss of urine					

Is there any family history in colon, uterine, breast, ovarian, or pancreatic cancer? Yes No

Are you of Ashkenazi Jewish ancestry? Yes No

Family Health Problems

Review the following list of health problems and check yes if they apply to parents, grandparents, siblings, aunts, uncles, or your children.

	Y	N	If Yes, please Indicate Maternal(Mother) or Paternal (Father) Relative	If Yes, please Indicate age when diagnosed	If Yes, please Indicate Alive or Deceased?
Diabetes					
Heart Disease					
Osteoporosis					
High Blood Pressure					
Stroke					
Blood clots					
Endometriosis					
Colon cancer					
Breast cancer					
Uterine Cancer					
Ovarian cancer					
Endometrial cancer					
Birth Defects					
Other					