

MEDICAL HISTORY

Name _____ Address _____

Date of Birth _____ Age _____ Phone _____

Occupation _____ Date _____

Marital Status _____

PROBLEM or REASON FOR VISIT _____

PREGNANCY RECORD

Never pregnant _____ Full-term _____ Premature _____ Miscarriages _____ Abortions _____ Living Children _____

(Include miscarriages and abortions)

YEAR	HOSPITAL OF DELIVERY	DUR. OF PREG.	DUR. OF LABOR	DELIVERY VAG/C SEC.	ANESTHESIA (GEN. SPINAL EPIDURAL, ETC.)	WT.	SEX	HEALTH OF INFANT AT BIRTH	COMPLICATIONS
List in sequence									

MENSTRUAL HISTORY

First day of last menstrual period _____ Age at first period _____

Number of days between 1st day of each period _____ Days flow lasts _____

Number of tampons/pads on heaviest days _____

Place an X beside any symptoms that apply to you.

- | | |
|---|--|
| <input type="checkbox"/> Recent change in periods
<input type="checkbox"/> Last period was unusual
<input type="checkbox"/> Bleeding between periods
<input type="checkbox"/> Bleeding after intercourse
<input type="checkbox"/> Pass blood clots
<input type="checkbox"/> Do not menstruate
<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Night sweats
<input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Pain associated with periods
How many days does pain last? _____
Does pain require medication? _____
<input type="checkbox"/> Periods cause you to miss work/school
<input type="checkbox"/> Bloating or swelling before periods
<input type="checkbox"/> Irritable before periods
<input type="checkbox"/> Emotional instability
<input type="checkbox"/> Crying spells
<input type="checkbox"/> Vaginal dryness |
|---|--|

If you do not menstruate, is it due to _____ Pregnancy _____ Menopause _____ Hysterectomy _____ Other _____

Do you think you may be starting menopause? _____ Yes _____ No

BIRTH CONTROL - Place an X where applicable to you.

- Not sexuall active
- Desire pregnancy
- Permanently sterilized
- Vasectomy
 - Tubal Ligation
 - Hysterectomy
 - Other

- Current method of contraception:
- Withdrawal
 - Rhythm
 - Foam suppositories
 - Condoms
 - Norplant - Year inserted _____
 - IUD Type _____ Year inserted _____
 - Depoprovera
 - Diaphragm
 - Cervical Cap

List contraception methods previously used

- Birth control pills
 - Name of pill _____
 - Dose _____ Year started _____

If you plan to use or are now using birth control pills, place an X by any problems you have now or had in the past:

- High blood sugar
- High blood pressure
- Hepatitis or jaundice
- Blood clots in veins
- Migraine headaches
- Other

SEXUAL HISTORY

- Not sexually active
- Pain with intercourse
- Sexual problem
- Desire sexual information
- New sexual partner since last exam

PAP SMEARS AND INFECTIONS

- Date of last pap smear _____ Results _____ Where performed _____
- Previous abnormal paps
 - Current Problems
 - Vaginal discharge
 - Vaginal irritation
 - Sores around vaginal area
 - Mother took hormones during your pregnancy
 - Past Problems
 - Infection of uterus, ovaries or tubes
 - Sexually transmitted diseases
 - Recurrent vaginal infections
 - Herpes
 - Genital warts or condyloma

URINARY SYSTEM

Place an X beside any symptoms that apply to you.

- No trouble with urinating now
- Trouble with urinating now
 - Burning
 - Blood in urine
 - Frequency
 - Urgency
 - Get up at night to empty bladder
- Bladder infection in Past
 - How many the past year? _____
- Lose Urine unintentionally
 - This is a problem for you with
 - Coughing, straining
 - Without warning
 - Requires change of clothing or protection
 - Previous bladder surgery

BREASTS

Place an X beside any symptoms that apply to you.

- Concerned about lump now
- Lump removed in the past
- Pain in breast
- Change in breast size
- Previous mammograms or x-rays of breasts
- Do not check breasts routinely
- Family history of breast problems

PAST HISTORY

HOSPITAL ADMISSIONS/OPERATIONS/INJURIES: (not for pregnancies)

Year/Age	Hospital	Operation or reason for hospitalization	Problems or complications

Childhood:

- German measles
- Rubella vaccine
- Mumps

- Rheumatic or scarlet fever
- Polio

Other Health Aspects:

- Blood transfusions
- Injuries or fractures
- Disability

Chronic Diseases:

- Tuberculosis
- Hepatitis or jaundice
- Phlebitis
- Blood clots in lung
- Nervous breakdown
- Insurance application refused
- Diabetes

- Thyroid disease
- Heart disease
- High blood pressure
- Anemia
- Asthma
- Lung disease
- Stomach or gallbladder problems

- Colitis or bowel problems
- Kidney disease
- Cancer
- Seizures, epilepsy
- Other

CURRENT SYMPTOMS

Place an X by those that apply to you NOW.

- | | | |
|--|---|---|
| <input type="checkbox"/> Weigh gain/loss | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hemorrhoid trouble |
| <input type="checkbox"/> Heat or cold intolerance | <input type="checkbox"/> Food intolerance | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Oily/dry skin | <input type="checkbox"/> Frequent loose stools | <input type="checkbox"/> Painful joints |
| <input type="checkbox"/> Unusual hair growth or loss | <input type="checkbox"/> Chronic constipation | <input type="checkbox"/> Prolonged bleeding after cut or extraction |
| <input type="checkbox"/> Worrisome moles | <input type="checkbox"/> Routine laxative use | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Complexion problems | <input type="checkbox"/> Trouble breathing | <input type="checkbox"/> Numbness of arms/legs |
| <input type="checkbox"/> Trouble with eyes/seeing | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Frequent severe headaches |
| <input type="checkbox"/> Trouble with ears/hearing | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Paralysis of arms/legs |
| <input type="checkbox"/> Chronic nose or sinus trouble | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Feel nervous or anxious |
| <input type="checkbox"/> Constant cough | <input type="checkbox"/> (if not pregnant) | <input type="checkbox"/> Feel depressed |
| <input type="checkbox"/> Cough up phlegm or blood | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Marital difficulties |

PERSONAL HISTORY

- | | | |
|---|---|---|
| <input type="checkbox"/> Smoke cigarettes | <input type="checkbox"/> Socially use alcoholic beverages | <input type="checkbox"/> Smoke marijuana |
| How many per day? _____ | <input type="checkbox"/> Excessive/problem alcohol use | <input type="checkbox"/> Exercise regularly |
| For how long? _____ | <input type="checkbox"/> Narcotics/IV drug use | How often _____ |
| <input type="checkbox"/> Cocaine use | | <input type="checkbox"/> Special diet |
| | | Type _____ |

