Name: ______________________________________ SS#: ____________________________________

Nickname: __________________________________ Today's Date: ____________________________

Address: ____________________________________ Home Phone: _____________________________

____ Work Phone: _____________________________

Date of birth: ________________________________ Cell Phone: ______________________________

Last Pap: ____________________________________ Last Mammogram: _________________________

Last Colonoscopy: _____________________________

Do you have new insurance today? ____ Yes ____ No Primary Physician: ___________________________

ALLERGIES:

Name/Type	Reaction

MEDICATIONS: (include over the counter medications)

Name	Dosage	# Times per day	Indication

HOSPITALIZATIONS AND SURGERIES:

Date	Reason	Date	Reason

MENSTRUAL AND PREGNANCY HISTORY

If you are **still** having periods:

Date of last period: ____________________________
Age your periods began: ________________________
# of days (start of period to start of next): __________
# of days your periods usually last: _______________
Menstrual flow: ____light, ____medium, ____heavy
# of tampons/pads used in one day: _______________
Do you pass clots?: ____________________________
Do you bleed between periods?:__________________
Birth control: ____yes ____ no
If no, how are you preventing pregnancy:
____

If you have **stopped** having periods:
Age of menopause: ______
Do you take prescription hormones?
____ yes ____ no
Did you take any hormones in the past?
____ yes ____ no
Do you take herbal hormones?
____ yes ____ no

FAMILY HISTORY:

Please list any known illnesses in your family members:

Mother:
____
Father:
____
Brothers:
____
Sisters:
____
Maternal Grandmother:
____
Maternal Grandfather:
____
Paternal Grandmother:
____
Paternal Grandfather:
____

SOCIAL HISTORY:

Occupation: _________________________________

Single Married Divorced Widowed Dating Minor
(circle one)
Spouse's name: ______________________________
Spouse's occupation: __________________________
Do you smoke: ____ yes ____ no ____ previously
How much per day: ___________________________

EXERCISE:

How many days per week:

____ 0 ____ 1-2 ____ 3-4 ____5+

What type: __________________________________
____

PREGNANCY HISTORY:

Total number of all pregnancies: _________________
Number of pre-term deliveries: _________________
Number of miscarriages: ________________________
Number of living children: _____________________
Number of full term deliveries: _________________
Number of elective abortions: __________________
Number of ectopic pregnancies: ________________

Date	Sex	Weight	Weeks Preg	Type of Delivery	Anesthesia	Location	Who delivered	Complications

GENETIC DISORDERS: (you or family members)

____Down's Syndrome ____Tay Sach's ____Cystic Fibrosis ____Sickle Cell

____Fragile X ____Other____

OB PATIENTS ONLY:

Have you ever had any of the following complications with your pregnancies?

_____ Congenital Anomalies
_____ Smoking during pregnancy
_____ Gestational Diabetes
_____ 2nd Pregnancy in 12 Months
_____ Infants weighing more than 9 lbs.
_____ Stillbirth

_____ Preeclampsia
_____ Multiple Births
_____ Neonatal Death
_____ Preterm Labor
_____ Thrombophlebitis
_____ RH Negative
_____ Other ___________________

_____ Genetic Diseases
_____ Incompetent Cervix
_____ Hypertension
_____ Advanced maternal age (over 35 at delivery)
_____ Hemorrhage
_____ Other ___________________

INFERTILITY TREATMENTS:

_____ Clomid
_____Artificial Insemination
_____In Vitro
_____ Injections
_____ Adoption
_____ Donor egg/Donor Sperm

PERSONAL MEDICAL HISTORY:

Gynecology:
_____Abnormal Paps
_____ Menstrual Cramps
_____ Endometriosis
_____ Fibroids
_____ Ovarian Cysts
_____ PCOS
_____ Infertility Problems
_____ Chlamydia
_____ Gonorrhea
_____ Genital Warts
_____ Herpes
_____ DES Exposure

Cardiovascular:
_____ High Blood Pressure
_____ Heart Disease
_____ Stroke
_____ Heart murmur
_____ Blood Clots/phlebitis
_____ High Cholesterol

Endocrine:
_____ Diabetes – juvenile/adult
_____ Hyperthyroid
_____ Hypothyroid
_____ Autoimmune Disease

Urinary:
_____ Bladder Infections
_____ Kidney Infections
_____ Incontinence

Breast:
_____ Abnormal Mammo
_____ Breast Cysts
_____ Breast Cancer
_____ Nipple discharge

Blood:
_____ Anemia
_____ Bleeding Problems
_____ Clotting Problems

Infectious Disease:
_____ Chicken Pox
_____ Shingles
_____ German Measles/Rubella
_____ Hepatitis

Muscle/Bone:
_____ Osteoarthritis
_____ Rheumatoid Arthritis
_____ Osteoporosis/Osteopenia
_____ Back/Disc Problems
_____ Fibromyalgia
_____ Injuries
_____ Chronic Fatigue Syndrome

Skin:
_____ Acne
_____ Skin Cancer
_____ Eczema
_____ Psoriasis

Lung:
_____ Asthma
_____ Emphysema
_____ Lung Cancer
_____ Pneumonia

Birth Defects:
_____ Cleft Palate/Lip
_____ Spina Bifida

Digestive:
_____ Colitis
_____ Chron's Disease
_____ Irritable Bowel Syndrome

Neurologic:
_____ Headaches
_____ Stroke
_____ Multiple Sclerosis

Mental:
_____ Depression
_____ Anxiety
_____ Mental Illness

Cancer:
_____ Uterine
_____ Ovarian
_____ Cervical
_____ Other ____________________