LINDA I. SODOMA DO DANIEL DOWSWELL DO KIM ANDERSON NP

MEDICAL HISTORY FORM

NAME________________________ BIRTHDATE________________

DATE________________________ SSN________________

I. What brings you to see the doctor?________________________

____

____

II. **Menstrual History**: Age when 1st period started________________

Are your cycles regular? **Yes** **No** Are your periods: **Regular** **Irregular**

How many days do you bleed? ______ How long are your cycles (average is 28-30 days______

How many days of heavy flow?______________Do you need double protection? **Yes** **No**

Do you have bleeding between periods? **Yes** **No** Are your periods painful? **Yes** **No**

How many days of pain per cycle? ________________

III. **Obstetric History** Number of: Pregnancies ________Miscarriages__________

Elective Terminations__________ Living Children________________

YEAR	MONTHS PREGNANT	COMPLICATIONS	BIRTH WEIGHT	SEX	COMMENTS

IV. **Gynecologic History:**

Date of last pap smear (mo/yr) ________ Have you ever had and abnormal pap? **Yes** **No**

Have you ever had an infection of your uterus, tubes or ovaries (PID) **Yes** **No**

Prior Gynecological Surgeries ________________________

____

____

Have you ever had Chlamydia, gonorrhea, herpes, genital warts or any other sexually transmitted disease? **Yes** **No** Do you have frequent vaginal infections/abnormal discharge? **Yes** **No**

Do you have pain/bleeding with intercourse? **Yes** **No**

Do you have more than one sexual partner? **Yes** **No**

When was your last mammogram?____________ Was it normal?____________

Any other significant past gynecological history?________________________

____

____

V. **Contraception:** Current Method (circle)

None Condoms Tubal Ligation Pills IUD Foam Norplant

Inserts Rhythm Vasectomy Diaphragm Withdrawal

VI. Family History

Relationship	**Age or Age at Death**	**Illnesses or Cause of Death**
Mother		
Father		
Sister(s)		
Brother(s)		

Any family history of (circle all that apply) **Diabetes** **Heart Disease** **High Cholesterol** **Alzheimer's**

Strokes **Breast Cancer** **Uterine Cancer** **Ovarian Cancer** **Other Cancers** **Osteoporosis**

VII. General Medical History

Do you have any ongoing medical problems?____

____

Prior Non-gynecological surgeries?____

____

List current medications:____

____

List vitamins and herbal supplements including doses______________________________

____

Allergies to medications____

____

List childhood illnesses____

____

Has your weight changed in the last year? Yes No If so, how much? ________________

Do you have problems with the following?

Head, eyes, ears, nose & throat (i.e. convulsions, visual difficulties, seizures,etc)	YES	NO
Breathing (i.e. cough, asthma, TB, valley fever	YES	NO
Hypertension	YES	NO
Diabetes	YES	NO
Heart Disease (heart attack, palpitations, chest pain, murmur)	YES	NO
Breast Discharge (milky, watery, bloody), Pain or Breast Lumps	YES	NO
Nausea, Vomiting, Diarrhea, Blood in Stool, Hepatitis	YES	NO
Kidney or Bladder Infection, Stones, Blood in Urine	YES	NO
Skin Problems (including excessive hair, hair loss, acne)	YES	NO
Emotional Problem (Depression, suicide attempts, anxiety)	YES	NO

Please explain any Yes answer____

____

VIII. Social History

Do you smoke? **Yes** **No** If so, how long have you smoked? ________Years Cigarettes/Day________

Did you smoke previously? ________________Years When did you quit?________________

Do you drink alcohol? **Yes** **No** What and how much?______________________________

Do you use street drugs? **Yes** **No** Identify drugs______________________________

Do you exercise? **Yes** **No** What type and how often?______________________________

Do you eat a balanced diet? **Yes** **No** Occupation______________________________